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ABSTRACT

This document contains prepared statements and witness testimony from the Congressional hearing on the elderly and alcohol and drug use. Opening statements are given by Committe on Aging representatives Edward Roybal and Michael Bilirakis. Witness testimony is given by representatives of the University of South Florida Gerontology Center; the Human Development Center of Pasco, Inc; Operation PAR; the Florida Mental Health Institute; Jack Eckerd Corporation (pharmacutical services); and medical doctors. Topics which are covered include incidence reports within the community and institutional settings, barriers to services, treatment modalities and programs, and financial demands and medical concerns with an elderly population. Private testimony and case studies conclude the document. (BL)

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ELDERLY: ALCOHOL AND DRUGS

ED247496

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

DECEMBER 7, 1983, PORT RICHEY, FLA.

Printed for the use of the Select Committee on Aging

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ELDERLY: ALCOHOL AND DRUGS

WEDNESDAY, DECEMBER 7, 1983

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Port Richey, Fla.

The committee met, pursuant to notice, at 9:00 a.m., in the Jewish Community Center, Port Richey, Fla., Edward R. Roybal, (chairman of the committee) presiding.

Members present: Representatives Roybal of California and Bilirakis of Florida.

Staff present: Jorge Lambrinos, staff director, Select Committee on Aging, and Saundra Hanbury, legislative director, office of Representative Bilirakis.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Mr. CHAIRMAN. Good morning, ladies and gentlemen.

The House Select Committee on Aging will now come to order. The House Select Committee on Aging is in session this morning to examine the problems which elderly people face with alcohol and drugs.

It is my pleasure to be here in Port Richey—an area with the fastest growing elderly population in the United States.

I want to express my appreciation to your Representative, Congressman Bilirakis for bringing the alcohol and drug problems of the elderly to the attention of the Committee on Aging. I also want to thank your Congressman for the great interest that he has shown in the House Select Committee on Aging. May I say that I can always depend on him to be present whenever we have hearings in Washington, D.C. This is real dedication to the cause of the senior citizens of this Nation and I want to publicly thank him for that at this time.

There seems to be much debate among the experts concerning the magnitude of alcohol and drug problems experienced by the elderly. In the case of alcohol, the percentage of elderly with alcohol problems are lower than for younger people. However, the percentage of elderly alcoholics is still high, with estimates ranging from 2 to 15 percent. The percentage of problem drinkers is even larger than the percentage of alcoholics.

In the case of drugs, the primary difficulty is not one of drug abuse as we usually think of it. That is, the elderly are not very likely to abuse drugs such as marihuana and heroin. Instead, the drug problem for the elderly is one of misuse of prescription and over-the-counter drugs. The elderly are 11 percent of the population but use nearly one-third of the prescriptions. On the average,

the elderly person takes four over-the-counter and prescription drugs each day. The percentage of elderly overusing prescription drugs may be as high as 10 percent or more.

The cost in human terms is very high because many of the elderly are left to face drug and alcohol problems all on their own. In addition, the cost in money terms is also high, with estimates ranging from the hundreds of millions to billions of dollars in added health costs.

Unfortunately, relatively little is being done by existing prevention and treatment programs to address the special needs of the elderly with alcohol and drug problems.

In today's hearing, the committee will hear from a series of witnesses testifying on the nature of the elderly's alcohol and drug problems throughout the United States. The witnesses will be asked to suggest what more could be done, what can the committee do, what can public agencies do, to help prevent and treat these problems.

I want to also thank at this time Congressman Bilirakis and his staff for helping to put this hearing together. I want to thank also the Bilirakis Senior Citizens Advisory Council and the Jewish Community Center for the valuable assistance they have given us in bringing this hearing to this site. We are taking advantage of their invitation, and, incidentally, this is free to the committee. We are not being charged a single dime to be present and to use this wonderful facility.

Towards the end of the hearing, we are going to use an old rule that we use in the House of Representatives; that is, a 1-minute rule. Under that particular rule any Member of the House can speak on any subject for 1 minute, that 1 minute, ladies and gentlemen, is 60 seconds. We are going to make the same privilege available to anyone in the audience who wants to take 1 minute to tell this committee anything they want. I hope it is with regard to the problem that we are discussing this morning. At the end of the hearing; that is, after we have heard from all the witnesses, all those who line up at that microphone in that aisle will be heard for 1 minute and this gavel will go down 60 seconds after you start.

The first witness this morning will be a director of gerontology. We are first going to ask him to start walking up to the microphones while I recognize your Congressman, Congressman Bilirakis, for an opening statement.

STATEMENT OF REPRESENTATIVE MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman. Before I begin my opening remarks on this most important hearing, I first want to thank you, sir, for coming to the Ninth Congressional District of Florida to chair this hearing to investigate the problems of alcohol and drugs in the elderly, something which seems to have aroused a great deal of concern across the Nation and in the bay area. I would like to share with the audience the fact that the Congressman is from California, he had to come an awfully long way. We are in a recess, that does not mean vacation, but it does mean an awful lot of hard work in our congressional districts and of course some family time. The Congressman has a tragedy which has oc-

curred in his own family that has been keeping him awake nights lately and a phone call is a concern that it might be bad news involving his sister-in-law. And I commend him that much more, and I know that we all appreciate that much more his having lived up to this obligation.

It is an important obligation, it is bringing Congress down to the people, it is so very difficult to bring the people to Congress. We do our best in that regard with our responsiveness, but this is an indication of bringing Congress to the people at the grass roots level.

To continue on, a survey taken in June of this year clearly indicates that our older Americans engage in a variety of unsafe medication practices such as doctor shopping; this happens an awful lot in this area, mixing prescriptions and the complications that are added by many over-the-counter drugs. This, Mr. Chairman, is not the only issue that we will focus on at this hearing—the other is that of the misuse of alcohol by the elderly.

I would like to cut my opening remarks short in the interest of time, but I do want to especially extend my thanks, as you did, Mr. Chairman, to Mr. Sid Klein, the President of this center, and the others here at the center, for so kindly providing the use of this lovely facility for today's hearing free of charge. Mr. Klein has worked closely with us on those special details that are so very important to the success of any congressional hearing. His efforts and those of the other folks here were invaluable and I too am most grateful to them.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Bilirakis.

The Chair will now recognize Dr. Jordan Kosberg, director of gerontology at the University of South Florida. Please proceed in any manner that you may desire.

STATEMENT OF JORDAN I. KOSBERG, PH. D., ACSW, DEPARTMENT OF GERONTOLOGY AND SUNCOAST GERONTOLOGY CENTER, UNIVERSITY OF SOUTH FLORIDA, TAMPA, FLA.

Dr. KOSBERG. Thank you.

The message I would like to bring is essentially two-fold; that the problem of alcohol abuse is under-recorded, and the resources available for those with problem drinking has scarcely reached the proportion needed.

As was earlier mentioned, various research has been undertaken on the extent of problem drinking in the United States. The National Council on Alcoholism, for example, estimated that approximately 10 percent of elderly men are problem drinkers and 2 percent of elderly women are problem drinkers. The Rutgers Center of Alcohol Studies, however, estimated the problem to be 7½ percent of the elderly are problem drinkers, and psychiatrist, Dr. Sheldon Zimberg estimates this proportion to be between 10 and 15 percent.

It is my contention that these figures, though high both in proportion as well as the numbers of elderly, are gross under-representations of the true extent of the problem.

First of all, problem drinking among the elderly is very much hidden, it is out of sight, it takes place within the confines of the home. Second, there is a failure on the part of professional care

providers to identify the problem for what it is. Related to this are missed diagnoses that are undertaken by those especially in health care facilities who assess the problem to be malnutrition, dementia, or depression, rather than the problem drinking that really is behind the condition.

Next, there is the denial by the elderly. That takes place in other age groups as well—denying that the problem exists. Their families, research has found, also keep the problem hidden. Some are embarrassed and so do not seek professional assistance.

Next, the reporting of problem drinking discriminates against the elderly. Often the reports are related to family disruption or employment problems, or arrests while driving under the influence of alcohol. The elderly too often can be widowed and therefore not in families; are retired and therefore not involved in employment settings; and perhaps cannot drive and therefore cannot be arrested for driving while intoxicated. As a result, the older problem drinker is often excluded from formal reporting procedures. And finally, perhaps most insidious, is agism which seems to exist among our social and health care resource staff. Unfortunately, there seems to be a pervasive attitude of "let them drink" because they have so very little else going for themselves. This has been found in research I have undertaken on categorical alcoholism agencies and certainly precludes any care and attention given to older problem drinkers.

Therefore, it is an underreported problem which these statistics seem to gloss over.

Related to this, there are research findings that of all older problem drinkers in the United States, only 15 percent are receiving attention, care, and treatment for their problem. Why is this? Why such a low proportion? In Cleveland, Ohio a couple of years ago, a colleague of mine and I did a study of 12 alcoholism agencies in the Cleveland area in our effort to ascertain whether there was overt discrimination against older problem drinkers.

While there was no overt discrimination per se, there were other policies that excluded the elderly from being served. First of all, they demanded that the clients that they see be ambulatory. Next, they wanted their clients to have work-related problems. Also, they expected their clients to come in for treatment and service. Related to this was the fact that there was no outreach, no education, no transportation component. Often, elderly individuals do need such assistance in outreach and transportation. So while these agencies did not overtly discriminate, neither did they provide any special assistance in reaching and serving older problem drinkers. I would quickly add that they did not have staff who were trained to work with older problem drinkers.

I also did a study, while in Cleveland, on over a hundred programs and services for the elderly to try to determine how the staff in these agencies dealt with older problem drinkers and I found that they were totally insensitive to the detection of the problem. Only in cases where an older participant was disruptive or dishevelled, could they identify the problem. The manner of handling the problem drinker, in such instances, was simply to ask the participants to leave. There was very little, if any, attempt to link up the

client to an alcohol agency or alcoholism programs, and staff was not trained to work with older problem drinkers.

The problem then, I think, is one of program delivery. Problem drinking elders seem to fall in the cracks of the service system in a community which cannot decide whose responsibility they are. Alcoholism agencies, I have found, do not identify the elderly as a priority client population. They, quite frankly, see the older problem drinker as no different than younger problem drinkers. I would like to return to this theme in a moment.

Is it the responsibility of programs and services for the elderly to meet all needs of the elderly? My experience is that they throw up their hands and say we are not trained to deal with the older problem drinkers. Or should we create special programs and services specifically for older problem drinkers? This question still remains to be answered, as best I can determine.

Finally, there are other questions that have research and treatment implications. First of all, are older problem drinkers different than younger problem drinkers? My experience and my research is that most people, especially in the alcoholism field, do not feel that there are differences, yet we know, based on clinical evidence, that there are at least two different types of older problem drinkers. The first is called the early onset drinker. This is a lifelong problem drinker who merely reaches old age. This group constitutes roughly two-thirds of older problem drinkers in our Nation. The remaining one-third are called either late onset drinkers or reactive drinkers. These are individuals who have been, at the worst I suppose, social drinkers who have reached old age, and as a result of some changes and problems related to aging and discrimination against the elderly, they have turned to drink as a coping mechanism.

Another question that begs an answer: Are all older problem drinkers alike? I would like to point out the fact that research has found that they are not all alike and this differentiation, I believe, has implications for differentiation in care and treatment of the elderly.

Finally, I want to go back to the beginning and state that the statistics that we hear are underrepresentations and that agency staff can no longer afford to wait in their offices for the elderly to show up on their doorsteps and say we have a problem. Demand does not equal need. I think that a much more vigorous and active stance is needed to more effectively address this problem.

Thank you.

The CHAIRMAN. Thank you very much. Will you please remain for some questions?

[The prepared statement of Dr. Kosberg follows:]

PREPARED STATEMENT OF JORDAN I. KOSBERG, PH. D., ACSW, DEPARTMENT OF GERONTOLOGY AND SUNCOAST GERONTOLOGY CENTER, UNIVERSITY OF SOUTH FLORIDA, TAMPA, FLA.

I. EXTENT OF PROBLEM

Even given variation in definitions of problem drinking, alcoholism, alcohol abuse, etc., research has found excessive drinking among the elderly is no small problem. Differences in the incidence of problem drinking have been found between the elderly in the general community and within institutional settings. Each will be dis-

cussed, in turn, as will be the invisibility of the problem and the under-reporting which results in low estimates of the actual extent of the problem.

A. Community surveys

In a study of the Washington Heights area of Manhattan, a survey included questions on alcoholism (Bailey, Haberman, and Alksne, 1965). The study found a peak prevalence of 23 per 1,000 population occurred in the 45–54 age group. The prevalence decreased to 17 per 1,000 for those 55–65 and then increased to a prevalence of 22 per 1,000 at the 65–74 year age group. The study noted that elderly widowers had a rate of 105 per 1,000 in contrast to the overall rate of 19 per 1,000. A study of United Automobile Workers Union members was conducted in Baltimore (Siassi, Crocetti, and Spiro, 1973) and it was found that 10 percent of the men and 20 percent of the women over 60 were heavy drinkers and could be considered to be alcoholics.

Carruth, et al. (1973) interviewed staffs of health, social service, and criminal justice agencies in three communities of differing populations to determine the extent of problem drinking among their elderly clients. The authors found that 45 percent of those interviewed had a contact with an elderly problem drinker in the previous year. It was also found that the alcoholism information and referral services surveyed reported that 30 percent of all calls were for persons 55 years of age and older. In San Francisco, it was found that of 722 individuals age 60 and over arrested for minor crimes, 82.3 percent were charged with drunkeness (Epstein, Mills, and Simon, 1970). This proportion of drunkeness arrests was higher than in any other age group. Schuckit (1977), in a study of alcoholism in Washington State, found 9 percent of all alcoholics in treatment were 60 and over.

Conservative estimates are proposed by the National Council on Alcoholism (1981a) who estimate that approximately 10 percent of the elderly male population are heavy or problem drinkers and 2 percent of the elderly female population. Based upon 24 million older people living in 1980, the estimate of those experiencing alcoholism and problem drinking could range from one to three million. The Rutgers Center of Alcohol Studies has estimated that alcohol abuse affects 7.5 percent of those 55 and over (Carruth, et al., 1973). The variations in geographic locations, definitions of problem drinking, and elderly populations studied make generalizations to Pasco and Pinellas Counties of questionable validity. However, the extent of problem drinking within community-based elderly samples cannot and should not be discounted or ignored.

B. Institutional settings

If rates of elderly problem drinking are considered high in the community, rates found among the elderly in long term care facilities and hospitals are higher. In a study of 534 patients over 60 years of age, admitted to a psychiatric observation ward in San Francisco General Hospital, it was found that 23 percent were alcoholic (Simon, Epstein, and Reynolds, 1968). A study conducted at a county psychiatric screening ward in Houston, Texas, found that 44 percent of 100 consecutive admissions over 60 were alcoholic (Gaitz and Greer, 1971). In an outpatient geriatric psychiatry program at Harlem Hospital in New York, 12 percent of the elderly patients were determined to have a drinking problem (Zimberg, 1969). Also, in a medical home-care program, 13 percent of the elderly patients requiring psychiatric consultation were diagnosed as alcoholic (Zimberg, 1971). Zimberg (1978) also found that 17 percent of patients 65 and over admitted to a suburban community mental health center had alcohol abuse as a problem on admission.

Blose (1978) estimated that alcohol problems among patients in Midwest nursing homes ranged from 40 to 60 percent, depending on the individuals, nursing homes, and the groups studied. Estimates have been made by Schuckit and Pastor (1978) that 2 to 10 percent of persons 60 and over, and up to 20 percent of some nursing home patients, suffer from alcoholism. They found between 15 to 20 percent of the elderly in general medical wards are alcoholics. One study of patients 65 and over admitted to the acute medical ward of a California Veterans Administration Hospital found 18 percent of these patients were alcoholic (Schuckit and Miller, 1975). Zimberg (1978) concludes his survey by suggesting: "... a reasonable estimate would seem to be 10 to 15 percent [of all elderly are alcoholic] with a higher proportion occurring among the hospitalized elderly." Blose (1978) indicated that alcoholism accounted for at least 12 percent of all white male admissions of those 65 and older to all types of inpatient psychiatric facilities. In a Washington State study of admissions to a detoxification facility, of 325 consecutive woman studied, 10 percent were over 55 (Schuckit, Morrissey, and O'Leary, 1979).

C. Underestimates of the problem

Given the large number of older problem drinkers found to exist in the community and a higher proportion within institutional and hospital settings, one is compelled to ask why there has been a general lack of attention by social service and health care providers. To begin with, problem drinking by the aged can be "invisible." This is especially true of the private drinker. Often drinking takes place within the confines of one's dwelling and is out of sight from the general community. Many elderly are retired and living alone, and so problems may go undetected by family and friends who do not interact with them on a regular basis (Synder and Way, 1979). As a graduate student, this writer worked as a delivery boy for a liquor store and there were daily visists to the homes and apartments of elderly persons. The alcohol would be left off at the door and an envelope with cash or a check would be waiting under the doormat. It was learned that groceries, too, were delivered and paid for in such a secretive manner.

Another explanation for the under-reporting and estimation of the problem is the fact that professionals and the lay public, alike, fail to identify problem drinking. For example, in a study of alcoholism among aged participants in social and nutrition programs funded by the local Area Agency on Aging (serving Cleveland, Ohio, and vicinity), the program coordinators cumulatively identified only 1 percent of 11,000 total aged served by the programs as problem drinkers (Kola and Kosberg, 1982). By any calculation, this is a gross under-reporting of the problem. What was especially telling was the fact that the majority of coordinators admitted that an older problem drinker would be identified only if disruptive to the other elderly participants or to staff by action, appearance, or smell. Coordinators also admitted that they and their staff were incapable of identifying problem drinkers who were not overtly disruptive.

Older alcohol abusers often have their problems assessed in terms of the symptoms of the drinking problems. For example, malnutrition, senile dementia, gastritis, depression, (or simply senility) may be seen to be the primary diagnosis in a health setting or the presenting problem is a social service setting. Intake workers are often untrained or not required to assess the reliability of medical records or clients' information to determine if problem drinking is—in fact—a major part in the presenting problems of an elderly person. Related to this is the fact that older persons may not admit to their alcohol-related problems. Families, too, keep the drinking problems of elderly relatives hidden from outsiders.

In equating alcoholism with the extent of drinking, there may be an under-estimation of problem drinking for the elderly. That is, it has been found that drinking declines with age (Marden, 1976). Among explanations for this finding are those which pertain to (1) differential mortality (between heavy and light drinkers) leaving a more "temperate group" (Marden, 1976), (2) the fact that capacity declines with age, (3) that there are fewer social occasions in whch alcohol consumption is sanctioned and encouraged, and (4) economic considerations (National Institute on Alcohol Abuse and Alcoholism, 1978).

For younger populations, information on alcoholism often is acquired in conjunction with family disruptions, employment problems, or driving while intoxicated arrests. For the elderly; who may be widowed, retired, and unable to drive; such reporting mechanisms result in unreliably low rates of recorded alcoholism for the elderly.

Finally, older problem drinkers may not be assessed as such, formally, because of an attitude of "let them drink." Such an attitude by families, law enforcement agents, and professionals in the alcohol and the aging fields is an example of ageism which reflects a view that the elderly have "little else going for them" and they have but a few years yet "to enjoy." Such a view glosses over the desire of an elderly person to eliminate the problem, fails to recognize the effectiveness of treatment for older problem drinkers, and results in the perception of the elderly as "second class" citizens.

D. Classification of older problem drinkers

While the above-cited surveys of alcoholism and problem drinking have provided useful information, the studies have failed to differentiate between the types of older problem drinkers and describe the characteristics of older problem drinkers. Older problem drinkers differ in the etiology and development of their problems which has, in turn, profound implications for prevention, identification, and treatment.

Cahalan, et al. (1969) found that older male drinkers are more likely to drink alone than are younger drinkers, more likely to drink at home, and more likely to say they drink because they have more free time to spend and for "social reasons."

(Younger persons indicated that they drink for enjoyment or for business reasons.) It was also found that older problem drinkers were more often binge drinkers and have more problems with relatives, friends, and finances than their younger counterparts. Carruth, et al. (1973) suggested that older drinkers are isolated from familial contacts and, to some extent, from other social contacts. Schuckit (1977) found elderly alcoholics included a higher proportion of men, Caucasians, and individuals with lower educational levels. Gomberg (1980) has found an interesting fact: That lower class elderly have both a smaller proportion of drinkers and a higher proportion of heavy drinkers. The rather limited and, often conflicting information on the characteristics of the elderly alcoholic is problematic because of differences between community-based problem drinkers and those within institutional and hospital settings. And there are differences between the characteristics of different types of older problem drinkers, as well.

The Carruth typology (1973, 1975) has placed problem drinking elderly into one of three categories. One type consists of individuals who have no history of drinking problems prior to old age and who developed the problem during old age. This group is called the reactive drinker. A second group consists of individuals who have intermittently experienced problems with alcohol, but in old age developed a more severe and persistent problem with alcohol. This group is called either the late-onset alcoholic or the late-onset exacerbation alcoholic. The third group consists of individuals who have a long history of alcoholism and continue their problem drinking into old age. This group is referred to as the early-onset alcoholic.

Zimberg (1978) believes that the second two types of alcoholics should be merged, as they describe longstanding problem drinking (and both should be referred to as early-onset alcoholics). The early-onset group accounts for two-thirds of all elderly problem drinkers and the reactive drinkers (or referred to also as late-onset in the dichotomized typology) accounts for one-third of all elderly problem drinkers (Rosin and Glatt, 1971).

The early-onset elderly problem drinker can be found in areas of transition, skid rows and other parts of cities and towns where chronic alcoholics of all ages seem to congregate. These life-long problem drinkers, who have become old, have been found to have personality characteristics similar to those of younger alcoholics (Zimberg, 1978). The late-onset (or reactive) problem drinker seems to have turned to excessive drinking due to the stresses of aging: depression, bereavement, retirement, loneliness, marital conflict, and physical illness. Drinking has become a coping mechanism. Zimberg (1978) believes both groups of elderly drinkers are reacting to stresses of aging (which can explain the spontaneous remission on the part of some early-onset alcoholics) and states: "Both groups of elderly alcoholics are reacting to stresses of aging, which, in producing a great deal of anxiety and depression, lead to the use of alcohol in the form of self-medication. . . . Therefore, the sociopsychological stresses of aging can prolong problem drinking in longstanding alcoholics into old age and can contribute to the development of problem drinking in later life for some elderly individuals" (p. 242).

Finally, some authors have differentiated elderly alcoholics with and without an organic mental syndrome (Simon, et al., 1968; Gaitz and Baer, 1971). Simon, et al. (1968) studied first admission psychiatric patients to the San Francisco General Hospital and defined three groups: (1) Alcoholics without chronic brain syndromes or, (2) alcoholics with chronic brain syndromes associated with senile or arteriosclerotic brain disease or, (3) with alcoholic brain disease. The first group was discharged back into the community within three months of admission (although not necessarily cured of alcoholism), the latter group had a poorer potential for discharge because of psychiatric and behavioral manifestations of their organic brain disorders, but also because a large proportion were seriously physically ill patients as well.

Zimberg (1978) believes that the early- and late-onset differentiation is a more useful approach than a distinction based upon psychiatric diagnoses. This view seems shared by most writers, researchers, and practitioners in the area of alcoholism and the aged.

II. TREATMENT OF THE OLDER PROBLEM DRINKER

This section will focus upon the treatment of older problem drinkers and explanations for the underutilization of alcoholism services by the elderly. A reminder is needed regarding the dearth of definitive and exhaustive clinical and empirical conclusions which seriously effects what is known about the causes, and also the treatment, of older problem drinkers, vis-a-vis, younger problem drinkers. As Mishara and Kastenbaum (1980) state: "Unfortunately, no comparative research that focuses directly on the differential benefits or liabilities of various treatment modalities for

younger and older adults has yet been done. Furthermore, there has not been adequate attention directed toward individual differences among elderly problem drinkers" (p. 92).

In addition, even where research findings or practice experience exists, there are disagreements and conflicting conclusions. This can readily be seen in the following discussions on the use of drug therapy for the elderly, abstinence as a goal for treatment, and the site for treatment of the older problem drinker, among others.

Two conflicting sets of findings are quite alarming: That the older problem drinker can be helped by treatment, but that the alcoholism services do not reach and serve the older problem drinker.

A. Barriers to service

". . . many clinicians affirm that aging people respond more positively to treatment than many of their younger counterparts" (National Council on Alcoholism, 1981b, p. 7). This statement is confirmed by the work of Schuckit (1977) who found that, compared to younger counterparts, the older problem drinker is more likely to drink daily but appears to have a better response to treatment, "with 73 percent completing therapy (vs. 40 percent for younger individuals) and only 15 percent (vs. 38 percent) for the younger men) leaving therapy before it is complete. Older alcoholics appear to require a shorter time period of time in treatment" (p. 173)

Both of the above quotations do not make distinctions by the type of problem drinking. However, Cohen (1975) observes that where alcohol abuse originates as a coping response to the stresses of aging, there is a good chance for treatment success. He is not optimistic, however, about the recovery possibilities for the geriatric alcoholic whose pattern of alcohol abuse emerged in early adulthood. Zimberg (1978) suggests, however, that there is a greater chance for successful rehabilitation even for the early on-set group of elderly alcohol abusers than there is for the younger career alcoholic. Finally, Gomberg (1980) also has found that for the elderly reactive (late-onset) problem drinker whose problem is a result of loss and stress, given treatment, "the prognosis is excellent" p. 16).

Given the possibility of successful treatment of the older problem drinker, the findings by Rathbone-McCuan and Bland (1975) that 85 percent of the elderly diagnosed as alcoholic were not receiving any help at all related to the problem is unfortunate. Although the study took place in Baltimore, a more recent report by the National Council on Alcoholism (1981b) estimated that "only 15 percent of those older persons in need of services for alcoholism are in fact receiving them" (p. 6). Whether or not such a generalization is either justifiable or accurate is another matter, the point is that there are explanations for the fact that elderly problem drinkers are not being adequately (and effectively) served by alcoholism agencies.

"Alcohol treatment centers are often reluctant to treat the elderly patient. Agencies often devote more attention to those clients who are able to demonstrate successful recovery in terms of restoration to gainful employment" (National Institute on Alcohol Abuse and Alcoholism, 1978, p. 6). Marden (1976) also found that the criteria for alcoholism program clients favored those who could demonstrate "success," i.e., employment found, health regained, or social acceptance assured. Those 20 to 50 years of age were preferred. In a study of nine categorical alcoholism programs in Cleveland, Ohio; Kola, Kosberg, and Wegner-Burch (1981) attempted to determine whether there existed overt discrimination against the older problem drinker. While none was found, per se, none of the programs had outreach components or transportation assistance, and most had policies restricting admission to persons who were ambulatory and not experiencing disabling medical problems. Therefore, there was de facto exclusion of many elderly alcoholics in need of treatment.

Aside from the issue of "success," attitudes toward the elderly are a factor in service to the older problem drinker. In one study on attitudes, Carruth (1973) found that problem drinking older people were viewed less favorably for treatment by those in the alcoholism field. Kosberg and Harris (1978) have documented inferior care and treatment to the elderly by professionals in the social service and health care fields. It is suspected that such ageism exists, also, within the alcoholism field.

Given problems with ambulation, with availability of transportation, and with restricted financial resources, there is a great need for active outreach and case-finding services, as well as effective home-care programs (Zimberg, 1978). Although the Gerontology Alcoholism Programs (of the Florida Mental Health Institute) utilized three outreach strategies to reach older problem drinkers (Dupree, 1982), such demonstration projects are rare; ongoing outreach efforts for the elderly are also not prevalent.

The dual-diagnosis of many older problem drinkers is another barrier to their treatment. As Rathbone-McCuan and Bland (1975) state: "Aged alcoholics who are

admitted to geriatric units have little chance of receiving treatment for alcoholism; those admitted to an alcoholism unit are not likely to receive treatment for the problem associated with old age" (p. 554). The problems are complex and include consideration of incomplete or inaccurate diagnoses, eligibility criteria for service, treatment skills of staff and treatment resources of facilities, and (last, but hardly least important) reimbursement policies and regulations of private and public health insurers. The overwhelming opinion among professionals working in the area of alcoholism and the aging is that a continuum of care of "aftercare" is crucial for successful treatment. Yet, many of the related support services ar not reimbursable under existing regulations. In fact, many alcoholics will be treated as inpatients simply because out-patient care is not reimbursable (National Council on Alcoholism, 1981a).

B. Treatment programs and modalities

There are a variety of treatment programs and modalities that exist or could exist for the older alcohol abuser. Such interventions include drug therapies, behavioral therapies, self-help groups, and psychosocial therapies. Each form of intervention has its proponents (and, often, opponents). Often interventions complement one another.

1. Drug Therapy.—Mishara and Kastenbaum (1980) have described drug treatment of the older problem drinker as being predicated on the belief that the individual suffers from "dysphoric symptoms such as anxiety or depression and unit drugs can reduce symptoms and reduce the need for alcohol for relief" (p. 93). Zimberg (1978); a psychiatrist with clinical experience in an outpatient geriatric psychiatric program, as a psychiatric consultant to a nursing home, and as a psychiatric consultant to a medical home care program; found that group socialization with—at times—antidepressant medication was effective in eliminating alcohol abuse as a problem. The use of disulfiram, Alcoholics Anonymous, or referral to alcohol treatment programs was not necessary. Lee (1978) has used antidepressive medication in the treatment of the clinically depressed problem drinker, along with group socialization and home visiting. Antabuse therapy is usually not needed for this group.

The use of medication in the treatment of older problem drinkers has received considerable discussion (and criticism). "The use of medication with alcoholic patients is a debatable issue and there are physicians who feel strongly that prescriptions of minor tranquilizers or sedatives for alcoholism is ill-advised. Attitudes toward disulfiram (antabuse) are also mixed . . ." (Gomberg, 1980, p. 17). Mishara and Kastenbaum (1980) have discussed the possibility of iatrogenic illnesses. Tranquilizers and hypnotic medications may cause brain syndromes (some not reversable) and "phenotiazine poses the danger of tardive dyskinesia" (p. 93). Older alcoholics seen in detoxification centers, according to Schuckit (1977), are less likely to receive antiabuse. This is probably due to the fact that the older problem drinker presents more medical problems than younger alcoholics and, thus, may be felt to represent a high risk for antiabuse therapy.

2. Behavioral therapies.—Such treatment modalities (including behavior modification) are increasingly popular and assume that alcoholism is learned behavior and, therefore, can be unlearned and alternative behavior can be substituted. Aversive conditioning results in clients associating uncomfortable feelings with the use of alcohol. With covert desenitization, a behavior modification therapist attempts to weaken the relationship between a psychological response and the problem that sets it off. At the Florida Mental Health Institute, the treatment of the older alcohol abuser emphasizes the learning or relearning of skills necessary to overcome behavioral deficits and personal and social losses. Such treatment may be combined with patients attending Alcoholics Anonymous meetings.

3. Alcoholics Anonymous.—Said to be the most effective form of treatment of alcoholism, Alcoholics Anonymous (A.A.) has reported that 60% of alcoholics attending the organization achieve sobriety within a year (Mishara and Kastenbaum, 1980, p. 94). A.A. is truely to be applauded for helping countless numbers of individuals with drinking problems through peer-group support. Unfortunately, some have referred older patients or clients to A.A. without thought. A.A. has not been viewed by all to be a panacea for every elderly problem drinker. While empirical research is meager, there is practice experience that some elderly—especially the reactive drinker—may not find A.A. appropriate to deal with their problems.

As Gomberg states: ". . . there is angry debate about sobriety as the goal of alcoholism treatment" (1980, p. 15). While sobriety is the foundation of A.A., the reactive drinker may wish to control drinking to social and periodic occasions. Should the treatment effectively resolve social and psychological problems (which had led to alcohol abuse), some would argue abstinence need not be a goal. Johnson and Good-

rich (1974) have found that moderate social drinking is associated in some older populations with good health and feelings of psychological well-being.

Other issues related to the appropriateness of A.A. for the elderly pertain to the exclusion of individuals taking medication, the religious orientation, public declarations, location and time of meetings, lack of supporting services (such as transportation), and the emphasis upon abstinence. Also, the heterogeneity of age groups and backgrounds of individuals at meetings could make some older persons uncomfortable. ". . ., the older alcoholic's problem differs from that of younger problem drinkers. He views his alcoholism differently. His reasons for drinking and his pattern of drinking are different. Being in treatment with a group much younger than himself may intensify his feelings of being old and out of place" (National Institute on Alcohol Abuse and Alcoholism, 1978, p. 2).

4. Psychosocial interventions.—There are those who believe that since psychosocial therapy treats the problems that generally cause older persons to drink, such interventions are ultimately the most beneficial. One can assume this means that such interventions are mainly for the reactive drinker. Zimberg (1978), however, found that "both early-onset and late-onset alcoholics responded equally well to their psychosocial interventions . . ." (pp. 242–3).

Treatment techniques include group therapy, family counseling, informal peer-group sessions, problem-solving, and development of new social skills and self-confidence.

5. Programs for the older alcoholic.—Programs have been developed in the country specifically for the older problem drinker. In a Minneapolis nursing home/treatment center, there is a program for elderly groups of chronic alcoholics who are generally without family contacts (Older Problem Drinkers, 1975). Individuals remain in the facility between three and six months and perform maintenance chores and handiwork, and attend weekly meetings of A.A. Before discharge, a counselor (who will maintain post-residence contact) plans with the client for living quarters, financial assistance, and participation in A.A. While there is no estimates on the recovery rate, staff believes there seems to be a beneficial impact on a group (of elderly chronic drinkers) not considered to have good prognoses.

A home for the aged in Toronto found that 6 percent of their residents had drinking problems and initiated a program to focus on the problem and the behavioral problems associated with such problems (Saunders, 1976). The program was designed to stimulate participation in nondrinking activities and in social relationships. While the program was not formally evaluated, about half of the participants showed increased activity and social involvement along with decreased drinking. The program does not require abstinence, but emphasizes diminished drinking and concomitant increase in other activities and sociability.

Glassock (1979) has written about the Helping Hands Program, a support group at the Alcoholism Treatment and Education Center of the Memorial Hospital Medical Center in Long Beach, California. The Treatment Center has an elderly inpatient population of 15 to 25 percent of all patients, and a special inpatient treatment program for the older alcoholic. Phase I of the program, detoxification and clearing, can take up to twice as long as for younger problem drinkers because of poor nutrition, weight loss, and physical impairments. Individual counseling and support are provided to help ease frustration and depression. Phase II includes daily group therapy, involvement of family, and—if sobriety is desired—referral to A.A. Reference is also made to Women for Sobriety, a special treatment group. Gomberg (1980) explains the special need for such a group: "Treatment plans for older women problem drinkers must take into account the triple stigma of being old, female, and alcoholic. Women clients may wish to join women's therapy groups or they may wish to join a self-help group (p. 21). Nothing has been written on treatment of minority group alcoholics.

C. Program settings

What should be the site for programs and services for the older problem drinker: in alcoholism programs, in programs for the elderly, or in psychiatric facilities? Should the programs be only for older persons or for all age groups? Here, again, there are no definite conclusions.

There are some who believe the categorical alcoholism agency or program is the most appropriate setting. "Alcoholism rehabilitation facilities afford the anonymity that is often desired—the security and protectiveness of being with other alcoholics during early sobriety" (Glassock, 1979, p. 22). Kola, Kosberg, and Wegner-Burch (1981) found that those responsible for alcoholism programs, although not giving any special attention to older problem drinkers, believed their staff members were the best trained and educated to work with alcohol abusers—regardless of age.

Zimberg (1978) is a leading advocate for locating treatment programs in age-segregated settings. Given denial, plus stresses and the multiplicity of complex problems, he believes it would be inappropriate to refer older individuals to alcoholism treatment programs and states: "Treatment interventions will be much more effective when delivered through facilities serving the aged, such as senior citizen programs, outpatient geriatric medical or psychiatric programs, nursing homes, or home-care programs. It is unlikely that significant numbers of elderly will be willing to go to an alcoholism program to deal with their problem drinking" (p. 246). Rathbone-McCuan and Bland (1975) also believe that alcoholism services need to be developed in conjunction with programs and services for the aged so that treatment for alcohol problems does not require change of a positive residential or community placement.

Finally, many within Alcoholics Anonymous maintain that meetings only for older problem drinkers is contrary to the principles of A.A. However, in areas with large numbers of older alcoholics, elderly speakers could help participants identify with similar problems. A.A. meetings could be located in age-segregated settings. Glassock (1979) identifies special A.A. programs for older recovering alcoholics in four communities in the Los Angeles Area.

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The CHAIRMAN. Will you cite for the committee the difference between a social drinker, a problem drinker, and an alcoholic?

Dr. KOSBERG. It is certainly a matter of degree. I feel compelled to beg off the question, because really it depends on how you are going to define and how you are going to measure those three types of drinking habits. Many instruments have been developed to measure the extent of the problem. Often there are instruments that have 10 questions and if you respond in the affirmative to 3 out of the 10 questions, then ipso facto, you are deemed an alcoholic.

I am not sure that these instruments are really that valid. I think a more thorough assessment of a person's life style is in order; the length of the problem, whether the drinking impinges

upon their life style, what the motivation of the problem drinker is, why he or she drinks. And so, I am not that comfortable with these differentiations because I think they are more differences in degree rather than differences in kind.

The CHAIRMAN. Well the reason I asked that question is because the statistics that you quoted seem to differ in some instances. For example, in 1978 Zimberg found that 17 percent of the patients 65 and over that were admitted to a suburban community mental health center had alcohol abuse as a problem.

Another study of the Veterans' Administration found 18 percent of these patients were alcoholics.

Most of these studies have found almost an equal percentage of alcoholics. I would like to know how they determined that the people were alcoholics and not problem drinkers?

Dr. KOSBERG. Well based on their definition of whether the problem was alcohol abuse, whether it was alcoholism or whether it was problem drinking. And the definition is in the mind of the definer and there are really no hard and fast definitions that are universally used by different researchers and clinicians.

The CHAIRMAN. This committee has been told on various occasions that alcoholism or problem drinking is a disease. I suppose the medical profession can measure the extent of a particular disease. If problem drinking and alcoholism is a disease, can one measure the extent of that problem.

Dr. KOSBERG. Well not being a clinician, I am not sure if you are asking a question related more to the physiological functioning of individuals or——

The CHAIRMAN. I am.

Dr. KOSBERG. Well then I would be unqualified to answer that question.

The CHAIRMAN. These are some of the things we hope to find out as we have these hearings throughout the country. I feel that while we find it necessary to have hearings on alcoholism and the elderly, I do not want a stigma attached to the senior citizen. We want to avoid someone saying that if he is a senior citizen, then he is an alcoholic. This can well happen. Senior citizens can also be nondrinkers, they can be social drinkers, and then they can go into the other category of problem drinking and alcoholism. And if alcoholism and problem drinkers come under the category of disease, then what is the cure? What can this committee do to alleviate the problem?

Do you have any recommendations to this committee, Doctor?

Dr. KOSBERG. Well terminology is very important. Certainly Alcoholics Anonymous have an interest in identifying the problem as alcoholism and in a way overstating the case merely to get someone to admit that they have a problem. In other agencies, other programs, they do not like to use that term because it has a certain stigma attached, so they perhaps would soften the language a bit and talk about "problem drinking." I have no solutions in terms of what to do about the terminology. It is going to vary anyway depending on the philosophy of the program and also the nature of the clients that are being served, whether they are early onset, lifelong problem drinkers, alcoholics if you will, or whether they are problem drinkers who have turned to drink more recently as a re-

action to the difficulties that they face. They may somewhat rebel against the notion that they are alcoholics, and indeed in the literature, there is some suggestion that abstinence is not a goal for them, although this is still widely being discussed.

The CHAIRMAN. Well there are certain things that we do know. We know that people drink and that the problem of alcoholism is higher in the younger group than it is in the elderly population. Am I correct in saying to you that the problem of alcoholism is higher in those under 55 than it is in those over 55?

Dr. KOSBERG. Yes, research has found that to be true.

The CHAIRMAN. All right. So we have that as an established fact based on statistics. We also have one other fact that I think we agree on, which is that regardless of the problem, even though the instance of this disease is not the highest in the senior citizen community, we find that we are not doing enough to help. Is that also a correct statement?

Dr. KOSBERG. I feel that that is a correct statement.

The CHAIRMAN. Now would it be possible for you to submit in writing to this committee, not at this moment of course, your recommendation as to what we can do.

As you know, this is not a legislative committee but this is a fact-finding committee, and this is what makes it important. As a fact-finding committee we make recommendations to the Congress. Can you make recommendations to us as to what we can do to bring about a better atmosphere and to provide a delivery service so that help can be taken to the senior citizens of this country?

Dr. KOSBERG. Yes.

The CHAIRMAN. Thank you.

Mr. Bilirakis?

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Kosberg, are some of the answers to the chairman's questions contained in your formal presentation?

Dr. KOSBERG. Some are.

Mr. BILIRAKIS. I would suggest that we will want your formal presentation submitted and made a part of the record, and I ask that that be done.

The CHAIRMAN. Without objection, it will be done.

[See p. 5 for Dr. Kosberg's prepared statement.]

Mr. BILIRAKIS. Dr. Kosberg, just quoting from your study very briefly, "The study noted that elderly widowers had a rate of 105 per 1,000 in contrast to the overall rate of 19 per 1,000." I think that is just a point that I wanted to make here today. And then a further study by the United Automobile Workers Union that was conducted of those members apparently in Baltimore it was found that 10 percent of the men and 20 percent of the women over 60 were heavy drinkers and should be considered to be alcoholics.

Then later on your testimony indicates that approximately 10 percent—this is another study conducted by the National Council on Alcoholism—approximately 10 percent of the elderly male population are heavy and problem drinkers and 2 percent of the elderly female population. There seems to be quite a contrast there and I just wondered if you wanted to address that very briefly.

Dr. KOSBERG. Well this, unfortunately, happens too often in research undertaken by different researchers of a similar topic, that

they are using different samples of elderly individuals, different instruments, different definitions. I know it troubles me as much as it troubles you, the fact that we cannot really pull things together and come to any definitive conclusion about the incidence of various problems. It is mystifying.

Mr. BILIRAKIS. What—and I know that this is all going to be a part of your—at least I trust it is going to be a part of your further presentation that you are going to submit to us for the record, but I would ask you what role should the Government play in this problem; Federal, State, local; if any.

Dr. KOSBERG. I would like to see the responsibility, if you will, for addressing the problem of elderly alcoholism or problem drinking be squarely and firmly placed in one branch of the Government, whether it is the National Institute on Aging, the National Institute on Alcoholism and Alcohol Abuse, the Administration on Aging—whether the emphasis is going to come from one branch, one department or another. I have a feeling that each assumes the other is going to do it and therefore no one really sees it as their primary responsibility. I think that the elderly problem drinker should be identified as a priority group for study by AAA among other organizations. I think this should filter down to State, regional and local levels as well, because I see similar problems at local levels. Whose responsibility is the older problem drinker, alcoholism agencies or aging services and programs at the local level? I would like to see responsibilities more clearly identified.

Mr. BILIRAKIS. Thank you. I would ask you just this last question. What role is the USF Department of Gerontology playing in this subject?

Dr. KOSBERG. Well, I think its involvement really is reflected by my own research in the area. I was brought to the University from the Midwest to essentially carry out research as a social worker committed to service provision, so I work with many agencies in Pinellas, Pasco, and Hillsborough Counties. Also, of course, problem drinking is inculcated into our curriculum and students are sensitized to the potential——

Mr. BILIRAKIS. Medical students?

Dr. KOSBERG. No, these are students who are working on masters degrees in gerontology as opposed to medical students.

I cannot speak for medical school faculty. I would suspect that there is some awareness of problem drinking.

Mr. BILIRAKIS. I think you indicated earlier you felt that was one of the problems, possibly the medical profession was not adequately prepared.

Dr. KOSBERG. Indeed.

Mr. BILIRAKIS. Thank you. I have no further questions.

The CHAIRMAN. Doctor, I would like to thank you for your excellent testimony. I would also like to include the entire text which you submitted to the committee, which is very interesting. It has statistics based on research and I believe it is excellent. Without objection, the entire text of this testimony will be included in the record at this point.

Thank you.

The next witnesses are two young women that are going to tell us a little bit about themselves. May I ask Virginia and Florence to please come forward.

Virginia, will you please start off the discussion.

STATEMENT OF VIRGINIA

Ms. VIRGINIA. Mr. Chairman, Congressman Bilirakis, ladies and gentlemen, I cannot stress strongly enough the dangers of mixing alcohol and pills, tranquilizers, antidepressants, sleeping pills, or other mind altering drugs. They are very addictive, and when mixed with alcohol, have a very adverse effect on the individual, even though taken hours apart.

I will tell you briefly how it affected my life. My husband died in March of 1982, after a long period of time in a hospital and nursing home. It was very depressing to see him disintegrate from the ravages of cancer. When I would visit the nursing home, I came out feeling very depressed and I had to cut my daily visits from every day to 2 or 3 times a week. During this interim, to keep up my courage, I would have a few drinks to keep myself going. I also took a Librium in the morning for my anxiety. Unknowingly, this was deadly for my own well-being. I did not realize it, nor was I aware that a pill in the morning and three or four drinks in the afternoon was a very deadly combination.

After he passed away, the drinking increased and I finally sought help at a treatment facility. After 28 days I was on an outpatient basis with a psychiatrist. I was prescribed tranquilizers for anxiety and depression, but the compulsion to drink was very strong and I could not stay away from alcohol.

Finally in September, I checked myself into the Suncoast Hospital, recommended by a friend. Here I received the therapy I needed. I was taken off tranquilizers, and withdrawal from pills and alcohol was very traumatic. I had cold sweats and could not sleep at night.

This hospital did not give me any addictive medication. After 2 weeks, I felt a lot better. Since leaving Suncoast Hospital, I have been on an outpatient basis with Dr. Brook and I have had no tranquilizers or alcohol since, for which I am extremely grateful.

Evidently the pills had triggered the drinking and I could not stay away from alcohol. Now I am free of this addiction and I pray it remains so.

Stress, due to the death of a spouse, and loneliness started this vicious cycle and I hope others do not fall into the same trap. Using alcohol to overcome problems does not work. The problems become magnified. I am now maintaining sobriety through a support group and have been attending almost every day of the week. I have no more anxiety or depression and I feel like a brand new person.

I sincerely hope I have thrown some light on the subject and that it may help somebody in the same situation.

Thank you.

The CHAIRMAN. Thank you so much.

Florence, will you proceed.

STATEMENT OF FLORENCE

Ms. FLORENCE. Mr. Chairman, Congressman Bilirakis, I am a grateful recovering alcoholic. My problem goes back to 1951 when my young husband died from polio and left me with a 5-year-old son and no money. I started to drink primarily to be able to cope with having to try to earn a living for the two of us and just to cope with everything in general. Of course you know when you are an alcoholic, you can always find an awful lot of excuses to drink. I drank all of my life.

I am not here to talk so much about alcoholism as I am about what drugs will do to you if you are taking any while you are an alcoholic. Six years ago, I took my last drink and I was a happy person until a little over 2 years ago. I had to have an operation on my back. The operation did keep me from being paralyzed in my right leg, but left me in almost constant pain. So I started on pain pills and for awhile they helped. Then all of a sudden the pain just seemed so intense that nothing would help it. So I went to another doctor and I got a different kind of pain pill and I started to take both of them. I was also taking a tranquilizer and I found that I could not go but 4 hours in between the regular doses so I took a few more. I was taking them a lot sooner and it seemed like all of a sudden I was getting sicker.

By that time I had been in bed for 4 or 5 days, I couldn't eat or sleep. All I wanted to do was cry, I was afraid to get in my car. I finally called a friend because I had been alone all this time and I found I could not even function properly, the pills even were not helping. She called a doctor and he put me in the Suncoast Hospital and explained to me that I had been substituting drugs for the alcohol. Even though I no longer drank, I was getting my high on the pills.

So once again by not being able to cope with my life and my problems, I was back on the same old merry-go-round again. I stayed there for the 28-day alcohol and drug abuse program. For 3 days you are kept on medications, I was terribly sick for over a week, I thought I was going to die and I wanted to, but you do get better. You attend lectures, movies, you have encounter groups and AA meetings every night. I got a lot of moral support from my family up north and from the staff at the hospital. If you have no family, everyone at the AA meeting makes you feel so welcome, you need never feel lonely again. I met many women there older than I and also young boys and girls, some only 13 and 14 years old and I thought about my grandson who could be there. There is no age limit for alcoholism or drug abuse. This program is the only thing some people have to hang onto. It must be kept going at any cost.

Thank you.

The CHAIRMAN. I wish to compliment both Virginia and Florence for being present this morning and making this presentation. I do not think you have any idea how much you have helped, but you have. You told this committee of your personal problems with alcohol and the mixing of alcohol and medication.

I would like to ask each one of you the same question. Both of you testified to the fact that stress itself induced drinking and that

drinking increased anxiety and increased problems. You also stated that you went to a private organization to get the treatment that was necessary. Did you try going to a public place of any kind provided by the community, if there is any? Was there any place where you could have gone that the Government makes available, whether it be the State, the city, or the Federal Government?

Ms. VIRGINIA. No; I did not know of any. I was going to psychiatrists and receiving no help and I just could not stop drinking and the pills just made it that much worse.

The CHAIRMAN. So then you had to go to a private place to get the treatment you needed?

Ms. VIRGINIA. That is correct, sir.

The CHAIRMAN. What about you, Florence, is the same thing true?

Ms. FLORENCE. For one thing you need the medical treatment you not only need the program but you need medical treatment and a lot of it, because you are really sick.

The CHAIRMAN. All right, that bears out the contention that alcoholism is a disease and that you do need medical treatment, but how does a doctor treat the individual. Let us go back to the time that your physician prescribed certain drugs. Did he tell you that this is a drug that you are going to take for anxiety, let us say, or whatever the situation is, but if you take it you must not drink. Was that ever said to you by a physician?

Ms. FLORENCE. Yes, sir.

The CHAIRMAN. What about you, Virginia?

Ms. VIRGINIA. Yes, it was said.

The CHAIRMAN. Then the doctor did prepare you for the fact that if you did any drinking with this, it would be detrimental to your health. But the mere fact that you craved the liquor made you forget about anything the doctor had said, is that correct?

Ms. VIRGINIA. I took one Librium a day, that is all. I did not take a quantity of pills, but the one Librium a day seemed to trigger the desire to drink. That is the point I would like to bring out. It triggers your desire to drink.

The CHAIRMAN. That was what I was trying to get to, whether the drinking took place because of the fact that you had medication before. Would that have taken place regardless of the medication?

Ms. VIRGINIA. I think it was a combination of things, stress, the whole bit, the whole thing. Now I have no desire to drink any more and—oh, in the early part of this year, the desire was terrible, awful, but I have just lost is completely.

The CHAIRMAN. Florence, what about you?

Ms. FLORENCE. Well my case is a little different because I had not drank for 6 years, but just because I had not drank, I went to pills. So as I say, I was just substituting one for the other. So I did not have the combination effect that she had.

The CHAIRMAN. So in your instance the pills did not induce drinking?

Ms. FLORENCE. No, not in my case.

The CHAIRMAN. Mr. Bilirakis?

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Virginia and Florence, you have given us your personal experiences with alcohol and drugs and we are very grateful. You heard

the testimony of Dr. Kosberg and some of the statistics as a result of surveys taken throughout the country. But I ask you, because you have been right in the grassroots with the people and you have had this experience, in your opinion, how much of a problem is alcohol misuse and alcoholism in the elderly, and we can tie that into the drugs of course. I ask you how much of a problem do you see in your community, your subdivision, whatever the case may be?

Ms. FLORENCE. It is getting more and it is getting more pervasive.

Mr. BILIRAKIS. You feel that there are a lot of elderly that——

Ms. FLORENCE. Yes, there are more elderlies showing up in hospitals and at AA meetings, you just hear it more.

Mr. BILIRAKIS. Virginia?

Ms. VIRGINIA. I agree with that. I know really of two people in my—where I live, in the surrounding area, that could use some treatment, but I would never interfere in their lives so I have never said anything.

Mr. BILIRAKIS. Do you have any advice that you would give to these treatment centers or treatment programs, particularly as they might better serve the elderly? Again, you know, you are people who have gone through this experience. Do you have any advice that you might give to them—give to us and maybe through us go to them?

Ms. VIRGINIA. Well for me, I must continue in AA, that is a must, that is your salvation.

Mr. BILIRAKIS. Do you have any advice to AA? In other words, any area you feel they might be able to improve upon.

Ms. VIRGINIA. You mean advice that I would give AA?

Mr. BILIRAKIS. In terms of treating you and other elderly who have had problems.

Ms. VIRGINIA. No, I cannot say that I could answer that, no.

Mr. BILIRAKIS. Florence, do you have any comments?

Ms. FLORENCE. I would try to have more encounter groups, advertise in the papers for the elderly on alcohol and drug abuse.

Mr. BILIRAKIS. Well, I would just like to finish up by telling the audience that there were a number of names of people such as Florence and Virginia that were given to my staff for the purpose of testifying. There was one other witness who had agreed originally, as I understand, and backed out, and there are a number of people who refused to testify. That is understandable and I know there are a number of people in the room here who would have been willing to testify if we had approached them, but of course we were not aware of their problem and they had not approached us before time, but I just echo the chairman's comments how very much I personally also commend Virginia and Florence for their bravery, and that is all that it is, bravery, in coming forward. We appreciate it so very much, you have rendered a fantastic service not only to our committee, but to the entire community and I applaud you.

The CHAIRMAN. Virginia, Florence, thank you very much.

The next panel will be made up of Ms. Maureen Shenan-Kelly, Dr. Leslie Brewer and Dr. Walter Winchester. Please come forward

and take your respective seats. Ms. Sherman-Kelly, will you start off this session?

STATEMENT OF MAUREEN SHERMAN-KELLY, DIRECTOR, SPECIALIZED MENTAL HEALTH SERVICES, HUMAN DEVELOPMENT CENTER OF PASCO, INC., NEW PORT RICHEY, FLA.

Ms. SHERMAN-KELLY. Gentlemen, good morning. First, let me express my appreciation for your coming here today, and grappling with the issue of substance abuse and the elderly, which creates such a significant impact on the lives of older persons, their families and their friends.

Pasco County ranks among one of the most rapidly growing counties in the country today. A major portion of the people moving here are retirees seeking a warm climate and reduced financial demands. In 1982, approximately 42 percent of the county's population were over 60 years of age and 48 percent were over 55 years of age. The census data projects a significant increase in the number of persons 60 years of age and older who will be moving to Pasco County over the next decade. This makes Pasco a microcosm for what may be occurring in the future at the national level, and a prime target for substance abuse and misuse among older adults.

The agency that I represent, the Human Development Center of Pasco, is a private, nonprofit corporation. We offer a network of mental health, drug and alcohol abuse services to Pasco County residents. So I am going to be speaking from that particular perspective.

Our Alcohol and Drug Abuse Department offers alcohol and drug counseling, alcohol detoxification, DWI schools and a variety of community education programs.

Senior Guidance Services, which is the department that I supervise, specializes in providing mental health services to people 55 years of age and older. We do this through an outreach model whereby we go into persons' homes, we will go into community based sites like the Elpher Senior Center or the Hunter Senior Center, and provide counseling on site. In addition, we provide a variety of educational programs as well.

What we have noted, and we are the primary provider of mental health services in Pasco County, is that due to the very nature of the problem of substance abuse, we find it very difficult to locate and treat older persons who may be abusing alcohol and medication. And we are talking about prescription and over-the-counter drugs. The elderly person who abuses or misuses alcohol and medication is not the kind of person who is easily visible in the community. We are dealing with the concept of "the hidden abuser." This is not the elderly skid row type alcoholic, you will not see that person in Pasco County. You will not see the older person who has misused medications wandering in a confused state down the street.

The hidden abuser is usually referred to our community hospital, physicians, sometimes home health care agencies or to our mental health agency for a variety of medical problems or forms of depressive illnesses and not for substance abuse treatment.

When a person comes to our center, we do an evaluation and assessment that includes a medical workup. In 85 percent of the cases that we see, we find one of three things: (a) The person is probably taking five or more medications and has absolutely no idea of how they are interacting, what they are doing to their bodies, (b) the person has received medication or a prescription from their physician but has not filled that prescription, possibly because they cannot afford it, that's one instance, or they cannot get to the pharmacy to fill the prescription and the third is that we find people are borrowing one another's medication, that is not uncommon. It does not sound like it makes a lot of sense, but if you live in a mobile home park and someone says this medication has made me feel better, I do not have time to go to the doctor, may I borrow some of yours; in fact, people are borrowing one another's medications. We find one of those things to be true in 85 percent of the cases that come to our center.

Studies indicate that the probability of successful treatment is good if you can alleviate the psychosocial factors the stress and the loss associated with aging. The losses that the two ladies were talking about erode a person's sense of well-being and self-worth. The stresses, physical illnesses, the increased financial demands, basically can in fact be largely influential in turning to alcohol or medication as a way of coping.

In treatment, what we attempt to do is help the person come to terms with the issue of loss in your life and the stresses that affect their lives, and develop new ways of coping with life. In addition we work with the phsyicians and one of our physicians on staff especially is creating a self-management medication regime. We also support the person if it is needed, and most cases it is, to go through our detoxification program, which is a 28-day program.

Our statistics are not very good. In our detoxification program we service over 600 people a year, 58 people were over the age of 55 last year, that is not a high percentage in Pasco County.

In addition, we do not reach a large number of older people who are abusing medication or alcohol. People come to us who are in crisis, they do not come to us before the crisis reaches the proportion where they are going to drink in excess or abuse medication. I believe that the major impact of substance abuse in the elderly is on the health care system. Studies have consistently shown that a minimum of 20 percent of all hospitalized persons have a significant alcohol problem, whatever the presenting problem or admitting diagnosis is.

Some of the studies that I have come in contact with from the Veterans' Administration estimate that 50 percent of all VA hospital beds are filled by veterans with alcohol problems. That is an enormous number statistically.

Medication abuse and misuse is reported to be very common among older persons in general. And as you mentioned, while there is little evidence that there is a problem with illegally obtained drugs, the basic problem appears to center around the abuses of legally obtained prescription and over-the-counter medications.

The studies that we have read indicate that 85 percent of persons over 65 have chronic health problems which require some type of medication. It has also been established that 3 to 5 percent of all

hospital admissions are due to adverse drug reactions and that amounts statistically to about 1.5 million hospitalizations and 30,000 deaths annually.

As I said, we do not see these people—when a person is brought into the emergency room of one of our hospitals they are usually not asked if they have—well they might be asked if they have taken a variety of medication, but the primary diagnosis is made on the person's presenting problem. The presenting problem might be a heart attack or other degrees of respiratory failure, but not an adverse drug reaction. The possibility of an elderly person experiencing an adverse drug reaction is high, as the population which represents 11 percent of the U.S. population consumes 25 percent of all drugs prescribed and probably a similar portion of over-the-counter medication. This high rate of consumption with its potential for misuse gives rise to concern for the overall delivery system.

As the average age of our country increases and there is a declining birth rate, the potentially at risk population also increases in size. Older adults will continue to be confronted with the various stresses associated with aging. Many who do not have a prior history of substance abuse or misuse will turn to alcohol or medication as a way of coping with life situations. The stresses of aging may be too great or come too fast or at the wrong time for people to cope with successfully. These are the people that we see in treatment.

I think if one considers the Federal dollars spent on health research, substance abuse and the elderly may be getting short shrift. Under the circumstances, I would recommend that the subcommittee consider allocation of additional moneys for research and treatment to address the issue.

Something that I did not write in my notes but I am beginning to feel very strongly about, having worked at Pasco specifically for the last 3½ years, is that since it is not likely that older adults who are experiencing substance abuse problems, even mental health problems, come to us, is the reason we developed an outreach model; we need to go to them. I believe one of the most effective ways to do it is through an education prevention program. We attempt to, in a small way, educate people to the stresses that happen when one gets older, but saying it and experiencing it are two different things, and these stresses come in groups, they do not come one at a time, and we are not prepared to handle them, no matter how well versed or flexible we think we are.

I believe what we do need is some sort of education prevention system, especially within this county, that can reach a large number of people. In addition I believe that a great deal of research needs to be done on the biomedical implications that go along with substance abuse.

Thank you.

The CHAIRMAN. Dr. Brewer?

[The prepared statement of Ms. Sherman-Kelly follows:]

PREPARED STATEMENT OF MAUREEN SHERMAN-KELLY, DIRECTOR OF SPECIALIZED MENTAL HEALTH SERVICES, HUMAN DEVELOPMENT CENTER OF PASCO, INC., NEW PORT RICHEY, FLA.

Gentlemen, first, let me express my appreciation for your coming here today, and grappling with the issue of substance abuse and the elderly which creates such a significant impact on the lives of older persons, their families and friends.

The Human Development Center of Pasco, Inc. is a private, nonprofit corporation offering a network of mental health, drug and alcohol abuse services to Pasco County residents.

The Alcohol and Drug Abuse Department offers alcohol and drug counseling, alcohol detoxification, DWI Schools and the TASC Program (Treatment Alternative to Street Crime).

Senior Guidance Services, a Department specializing in providing mental health services to persons 55 years of age and older offers individual, group and family counseling in the home, at community based sites and in the traditional outpatient clinic setting.

Pasco County ranks among one of the most rapidly growing counties in the country today. A major portion of those persons moving here are retirees seeking a warm climate and reduced financial demands. In 1982, approximately 42 percent of the county's population were over 60 years of age and 48 percent were over 55. The census data projects a significant increase in the number of persons 60 years of age and older moving to Pasco over the next decade. This makes Pasco a microcosm for what may be occuring in the future at a national level, and a prime target area for substance abuse and misuse among older adults.

And yet, due to the very nature of the problem, we find it difficult to locate and treat older persons who may be abusing alcohol or misusing medications (both prescription and over-the-counter).

The elderly person who abuses or misuses alcohol or medications is not the kind of person who is easily visible in the community. We are dealing with the concept of the older person as a "hidden abuser".

You will very seldom see the elderly skid row type alcoholic in Pasco County. You will not see the older person who has misused medications wandering the streets in a confused state.

The "hidden abuser" is usually referred to hospitals, private physicians, home health care agencies or the community mental health center for a variety of medical problems or forms of depressive illnesses and not for substance abuse services.

The process of growing older exposes the individual to a series of stressful and potentially difficult periods of readjustment. There are four areas of stress that need to be considered during this time; stresses that arise from social factors, biological or physical problems, psychological factors (where the common denominator is loss—losses which often come in bunches and are steady and predictable and erode a sense of well-being and purpose), and unfortunately stresses due to the way in which the helping professions serve (or inadequately serve) the older person.

The best predictor of the future, specifically of how someone will handle growing old, is how the individual has handled the previous years. Individuals who have demonstrated flexibility as they have gone through life will adapt best to the inevitable stress that comes with getting older. Everyone going through life relies most heavily on the coping styles that seem to have worked for them in the past. With years and years of living, gradually individuals narrow down their responses. What looks, initially, like an egocentricity or eccentricity of old age is more likely a lifelong behavior that has become one of the person's exclusive ways of dealing with stress.

It is significant that we were unable to get an older person to testify as a witness before this subcommittee today. Even those persons who felt they had successfully recovered from alcoholism (late life onset), and those who had mastered control over their medication regimen were fearful of speaking out in such a public forum. The fears of embarrassing one's family or attaining notariety outside the safety of their closest support group was given as the primary stumbling blocks to those we approached about being here today. Not even the potential gains to be won on a broad scale could offset the concerns for privacy.

In counseling we have successes and we have failures. Each is of importance because we come to recognize that in considering the outcome of treatment for the older person, we are really talking about ourselves in the future, and of our own abilities to make transitions in our lives and in our behavior.

Studies indicate that if the external factors (psychosocial losses/stresses) can be alleviated, the probability of successful treatment is good. However, few communi-

ties have developed specialized programs prepared to meet the unique needs of this population.

The major impact of substance abuse and the elderly is on the health care systems. Studies have consistently shown that a minimum of 20 percent of all hospitalized persons have a significant alcohol problem, whatever the presenting problem or admitting diagnosis is. The Veterans' Administration estimates that 50 percent of all VA hospital beds are filled with veterans with alcohol problems.

In terms of health care costs, alcohol figures prominently in our nation's annual bills. Medical costs of $12.8 billion annually for alcohol-related problems represent 12 percent of all adults' health expenditures.

Medication abuse and misuse is reported to be very common among older persons in general. While there is little evidence that there is a problem with illegally obtained drugs, the basic problem appears to center around the abuses of legally obtained prescription and over-the-counter medications.

About 85 percent of persons over 65 have one or more chronic health problems which require some type of medication. It has also been established that 3 to 5 percent of all hospital admissions are due to adverse drug reactions which amounts to about 1.5 million hospitalizations and 30,000 deaths annually.

The possibility of an elderly person experiencing an adverse drug reaction is high, as the elderly population, which represents 10 percent of the U.S. population, consumes 25 percent of all drugs prescribed and probably a similar proportion of over-the-counter medications. This high rate of consumption with its potential for misuse gives rise to concern for the overall service delivery system.

As the average age of the country increases due to declining birth rates and increased longevity, a potentially "at risk" population also increases in size. Older adults will continue to be confronted with the various stresses associated with the aging process, and many who do not have a prior history of substance abuse or misuse will turn to alcohol or medication as a way of coping with their particular life situations. The stresses of aging may be too great or come too fast or come at the wrong time to be dealt with successfully.

If one considers the federal dollars spent on health research, substance abuse and the elderly is a health concern that may be getting short shrift. Under the circumstances, we recommend that the subcommittee consider allocation of additional monies for research and treatment to address this issue.

We are all seeking answers and solutions. People are becoming aware of the toll substance abuse can take on public and private lives. What we will individually and collectively do with this information is the challenge.

Thank you for giving me the opportunity to speak today.

STATEMENT OF LESLIE BREWER, D.O., P.A., CLEARWATER, FLA.

Dr. BREWER. I would like to preface my remarks by just saying that I am a private psychiatrist who specializes in the area of alcohol and drug abuse and in preparing these remarks, these were basically the important things that I see from my standpoint in treatment.

This country is entering an era in which an ever increasing proportion of our population will be over 65. At the same time, we have become increasingly reliant on chemical solutions to problems of daily life and are applying them to an ever greater number of physical and emotional problems. The confluence of these conditions signals a problem for the health and well being of a large segment of our population.

In a study of 100 consecutive patients at our chemical dependency program at Sun Coast Hospital, one-third were 61 years of age and older. Of these, about 50 percent were early onset alcoholics who had had problems with addiction on and off throughout their lives, 25 percent were late onset alcoholics who used chemicals in response to the stresses of aging, and about 25 percent were late onset chemically dependent persons addicted as a result of prescription medications used for various medical problems over the years.

Chemical use by the aged is particularly dangerous for several reasons. The most obvious is that the body systems of the aged are in a general decline. Add to this the fact that alcohol mixed with prescription and over-the-counter medications causes potentiation of the drugs effects and also results in multiple drug addictions in the same individual. The elderly are completely trusting of their doctors and their pharmacists and the advice that they give them and the prescriptions that they give them; and the doctor, the pharmacist and the patient fail to realize that these chemicals often are making the patient worse rather than better. No one is thinking of the symptoms in terms of a chronic drug addiction, tolerance and withdrawal problems.

In fact, elderly alcoholics often do not fit the standard descriptions of people with alcohol problems. A spouse does not complain about the drinking because the spouse is dead. The employer does not complain about the problem because the patient is retired. The doctor attributes the physical deterioration, the falls, the mental confusion and the social isolation to be the effects of physical illness and aging and ends up prescribing more drugs, overlooking the real diagnosis of alcohol or drug dependency.

Once an elderly alcoholic is identified as needing treatment or that they have a chemical dependency, and they do go into some type of treatment, there are several other types of problems that arise. The first problem is that often these patients are treated in a geriatric unit or a psychiatric unit and each unit is really inappropriate for this type of care. These patients require treatment in a program designed for alcohol and drug rehabilitation with a goal of having the person become drug free and fully functional again.

The second problem is that treatment centers often have physicians involved in the treatment process, since these are their patients, who do not understand addiction, geriatrics, or both, when it comes to prescription of medication to the patient while they are in treatment. Really there is little that the treatment staff can do oftentimes if the physician insists on maintaining his patient on some type of drug during the treatment process, when the whole purpose of the treatment is to teach these individuals to become functional without drugs. Now there are many well trained physicians in the field of addition who fully understand the nuances of what they are doing in the treatment of this disease. Unfortunately, there are many more who think they know how to treat alcohol and drug problems, especially in the elderly, and oftentimes their treatment complicates the disease rather than helps it. These alcohol and drug rehabilitation centers, therefore, should be headed by and run by physicians who have specific training in alcohol and drug rehabilitation. Subspecialty certification in this area would be of tremendous benefit in maintaining and improving quality of care in this area. So one of the recommendations I would make would be that we should have subspecialty certification in this area.

The third and most pressing problem, however, that I see on a day-to-day basis is that in elderly patients everything takes more time than in a younger person. This includes the time it takes to get them off of chemicals and the time it takes to teach them how to stay off. The standard inpatient rehabilitation length of stay for

a 20- to 50-year-old is about 28 days. For alcoholism complicated by cross addiction to other drugs; for example, alcohol plus Valium, the usual time is about 6 weeks, again for a 20- to 50-year-old. Now a 65-year-old alcoholic, whether there is other drug addiction involved or not, comes to treatment with only 21 days of treatment being allowed by medicare. It often takes 2 to 3 weeks just to get this person mentally and physically able to begin to understand what is going on in the rehabilitation process and really begin treatment. So it is at this point then, oftentimes in the private setting, that we are forced to discharge the patient out of treatment before they are really ready, only to have them return a few weeks later in worse shape than they were before. So these people routinely need say 6 to 8 weeks of inpatient treatment and so one of the other recommendations I would propose would be that the routine amount of time allowed by medicare be increased to meet the needs of the elderly.

I appreciate your giving me the chance to express these feelings.

The CHAIRMAN. Thank you, Doctor.

The Chair now recognizes Dr. Walter Winchester.

STATEMENT OF DR. WALTER WINCHESTER, DUNEDIN, FLA.

Dr. WINCHESTER. Mr. Chairman, Mr. Bilirakis, my medical practice is primarily geriatric in scope. I see only a few patients each day, usually less than 10. In the past three decades I can recall only a few patients over the age of 65 in that group who were chronic alcoholics to the point where they got into significant troubles, the skid-row type; but I have seen many patients who were heavy drinkers, beginning at breakfast and continuing through the day. Many of these, I would not have ridden in an automobile with them had they been driving. By contrast, I have seen far more of the elderly patients abusing sedatives and tranquilizers.

During the past 12 months one of our large general hospitals in Pinellas County there were 25,000 discharges. One-fifth of these patients were between the ages of 65 and 75, and a fourth of the discharges were patients 75 and older. These two groups accounted for 58 percent of the patient days in the hospital.

Primary diagnoses where alcohol or drug or barbituate dependence numbered 166, and only 34 of these were over the age of 65, an average of about 1 a month. Thus in a general hospital in a population slanted toward a higher percentage of the aged, the drug and alcohol does not appear to be a primary diagnosis.

It must be noted that if the patient was admitted with a fracture from a fall at home, or an automobile accident, that the primary diagnosis would be the fracture and not the predisposing cause, which might very well be alcohol or drug related.

At another hospital in Pinellas County, specializing in nervous and mental problems, I am told that 15 percent of all admissions for those over the age of 65 will be for alcohol or drug related.

In talking with one of my colleagues this week who is a practicing nephrologist, I learned that in Pinellas County there are 450 patients on dialysis three times a week, and that the average age of these patients is 68. Thus of the elderly, there must be 225 to 250

in this category, and the costs for which are about $25,000 a year. In medical terms, this is for end stage renal disease.

Ten percent of these end stage renal disease patients developed their problems from abuse of analgesics and sedatives many of which are available over the counter, including APC, BC, Goody Powders, Bromoseltzer, Alka Seltzer, and some other drugs such as Darvon Compound, Fiorinal, to name just a few.

Automobile accidents exert a terrible toll on morbidity and life in our country. During the day, it has been said that 1 out of every 20 drivers on the road is under the influence. In the evening hours, this may be one out of every five drivers. The problem is compounded with the use of sedatives and tranquilizers. No doubt one of the advantages of the elderly then is their willingness to voluntarily restrict their driving to day time hours.

Physicians do not like to confront patients with abuse of alcohol.

Medical education produces tremendous demands upon the student and upon the faculty, the latter vying for every hour of study time they can obtain for their favorite medical problem. The topic of drug abuse and alcohol abuse gets precious few hours in medical schools, and when I was in medical school, the time was still less. The entire body of medical knowledge doubles every 10 years. There is not time while in school. And pressures continue during the formal hospital training time and are not much reduced when a physician enters private practice, for the kind of medicine that he wants to be practicing during his life. The chronic alcoholic is a difficult patient, frequently abusive, unappreciative of help, and relapses despite physicians best efforts. The physician is sometimes human and he often takes these relapses as failures of his own professional care.

As patients age, their mental faculties slip, sometimes more than they realize. Many cannot remember if they have taken their needed medicine, and often will take a pill a second time; in effect, overdosing. Others forget entirely to take the medicine. Many elder patients go to several physicians, each of whom may prescribe a separate medicine for each symptom, not compare notes with other doctors. Drug interactions may result and toxic patterns emerge.

Pharmacists often prescribe over-the-counter medicines for patients, not knowing what other medicines they might already be using. All too few pharmacists keep patient profiles; that is, a list of all the drugs that a patient might be taking. Profiles are particularly difficult to maintain when patients use many different drug stores.

So what might be done? In a culture which identifies alcohol as acceptable and as evidence of maturity in an individual, it is difficult to forcibly restrict its use in a society which prizes its freedom to be sick or well. The current emphasis on physical fitness in the younger group may represent a line of attack on the problem.

Such an emphasis might be encouraged by requiring every person to keep a copy of their own health record, listing all dates, visits, medicine, surgery, accidents, problems. As a very mobile population, it is becoming almost a necessity.

All pharmacists should be encouraged to keep patient drug profiles, and perhaps via some computer data bank, be able to share with other pharmacists.

Every practicing physician, especially those in primary care, should have a compendium, perhaps organized by States, that serves as a social service agency. By having current information within the office setting, each physician or his assistant, is in a position to make quicker referrals to appropriate agencies or facilities to take on the specialized problems of drug abuse and alcohol abuse. Usually patients, and their families, trust the physician of their choice and are more willing to accept additional help if offered by the physician, rather than by the possible chance of sidewalk consultations with friends to lead them to this or that agency. Physicians have on their desks already a book with a new edition annually on drugs, called the physicians desk reference. He needs one on agencies too. Perhaps your committee can help with production of such a book and such a movement in this country.

Thank you.

The CHAIRMAN. Thank you, Doctor.

I would like to start the questioning now by asking Ms. Kelly some questions with regard to the Human Development Center of Pasco County. That is a nonprofit organization, is it not?

Ms. SHERMAN-KELLY. That is correct.

The CHAIRMAN. The individuals who go there have to pay a fee, whatever it may be.

Ms. SHERMAN-KELLY. We operate on a sliding fee scale and in fact if someone is not able to pay, then we can waive payment, and we also, are you are probably aware, take third party billing from insurance companies and medicare.

The CHAIRMAN. All right, what I was getting to was whether or not medicare patients pay a sufficient amount to cover the cost of their treatment.

Ms. SHERMAN-KELLY. Yes.

The CHAIRMAN. Because if it does, that is the first time that I know of that medicare takes full responsibility.

Ms. SHERMAN-KELLY. I would not say full responsibility.

The CHAIRMAN. But it does help substantially, is that correct?

Ms. SHERMAN-KELLY. It helps substantially.

The CHAIRMAN. You made several recommendations, but before you did so, you said that it is hard to identify elderly with alcohol and drug-abuse problems.

Ms. SHERMAN-KELLY. That is correct.

The CHAIRMAN. Will you elaborate on that?

Ms. SHERMAN-KELLY. Probably—I believe the ladies said it best. We attempted to get some witnesses and, perhaps that is the best example, I talked to our substance abuse people and gerontology people, and spoke to several witnesses who did not want the notoriety, who were very frightened of embarrassing their families by going public in an open forum. No matter what good could come out of this type of hearing, they were very, very embarrassed. I think it takes special, unique people like those two ladies who were willing to get up and say this is who I am, this is what has happened to me.

The CHAIRMAN. In other words, it takes people like Virginia and Florence to come up and tell the committee as it is.

Ms. SHERMAN-KELLY. Yes, I believe so. In addition, I think the other problem is that none of us want to admit that we have a

problem with alcohol or with medication abuse. When people come in, they will—if they do come in, they will tell us initially some of their problems with their spouse or their children or that they are having difficulty in retirement, and when we begin to ask about their drinking habits and their medication regime, they will not really be very clear because they have never asked the question or they will not know, they will be too embarrassed to tell you. So I believe that is part of the difficulty that—the stigma of being identified as a user or misuser is incredibly great in our culture.

The CHAIRMAN. Thank you.

Dr. Brewer, you and Ms. Kelly agreed on one recommendation that more money be made available for research and study. You also recommended that the prevention of problems has to be accelerated by someone such as the Federal Government. Then there is the matter of a cure. So it seems to me these things are placed in three categories. Do you feel that in all three categories it is the Federal Government's responsibility to at least demonstrate to the other agencies that something has got to be done with respect to research, prevention and cure?

Dr. BREWER. Yes, I do. As I mentioned before, this is a very stigmatizing problem. People are unwilling to talk about it, unwilling to identify themselves with the problem, and this extends throughout the entire population, not just the elderly and it extends into the Government too. The Government is just an extension of society.

The CHAIRMAN. Doctor, this would lead, would it not, to the certification of specialists in this field?

Dr. BREWER. I would like to see that. When I had my training in medical school and later psychiatric residency training, I got no training in alcohol and drug abuse. There was nothing in the curriculum at all. And I was in general practice for awhile before going into psychiatry and did a lot of alcohol and drug abuse work. I ended up training the residents in the psychiatric program in alcohol and drug abuse, because nobody on the staff was able to do that.

The CHAIRMAN. Well I would like to see the situation, Doctor, where the Federal Government and particularly the medical profession would lead a program that would result in the certification of these individuals. Perhaps it should be done by the medical profession at the insistence of the Federal Government, or maybe some combination of the two. This is something the committee will have to look at.

I agree with you on the matter of certification. Prior to the time that you testified, I was not sure that I would be in favor of such a thing. However, I want you to know that you have convinced me.

Dr. BREWER. I appreciate it.

The CHAIRMAN. You have not been alone in convincing this committee. Dr. Winchester has helped as well because he said that very few hours are spent in medical school studying the effects of alcohol and drug abuse. What do you mean by very few hours, Doctor?

Dr. WINCHESTER. According to the recent Journal of Medical Education, less than 10 hours in an entire medical curriculum of 4 years, can be specifically designated for that. There are very many

fringe times when people are studying depression and studying chemistry as far as the liver is concerned and so forth, but specifically designated for this, there would be less than 10 hours. But in the average medical school curriculum there are 4,000 hours of available time and the entire faculty in every medical school is vying for those hours and the actual curriculum has changed over a period of time, in the time that I have been watching medical schools, but there still is not time for every professor to have as many hours for the topics that he feels every medical student should have before he finishes school.

The CHAIRMAN. Well Doctor, doctors in general specialize in many things, is this one specialty that is being neglected, or do you consider it to be a specialty?

Dr. WINCHESTER. No, I do not consider it to be a specialty and yet it can be a specialty. If you are interested in it, it is a specialty. I think I am interested in a more important specialty, that is one of people, I am a family doctor, a general practitioner. So we need people that are interested and have specialized skills and techniques.

The CHAIRMAN. But Doctor the general practitioner is almost disappearing. From what I hear and see in the medical schools, and there are many in my own district, almost every young man or woman who goes to medical school wants to specialize in something. I would like to see more MD's practicing family medicine, someone that I can go to for example if I have a problem with drug abuse or alcoholism. Because they are an MD, I would have confidence in their medical ability and they are friends of the family. That combination I think can result in my changing my way of life. I am using myself as an example because I think that I have tremendous confidence in my own personal physician and he happens to live right across the street from my home time in Los Angeles. I do not say that he is any better qualified than anybody else, but to me he is because I have confidence in him. That is why I think that the family doctor, the general practitioner, is so important. When I see that only a few hours, for example, are made available in medical schools for the problems of alcohol and drug abuse, I am saddened by the fact that that is the situation.

Now following the suggestions made by both Ms. Kelly and Dr. Brewer with regard to specialization, do you think that certification of experts in this field is a necessity?

Dr. WINCHESTER. Well you can argue for both sides. I personally am oriented toward the family physician point of view. If I could study each disease entity that comes into my office for a period of 1,000 hours or 2,000 hours, I might be able to start practicing medicine when I reach the age of 150. Unfortunately, I doubt that that would be very possible. I wish that there were mechanisms to make every physician superspecialists in every field, but obviously everybody likes to particularly direct his practice toward a specific interest in his field and obviously this is an area for people that are particularly interested in the field. If they qualify for a special—by special training, then they should be so recognized.

The CHAIRMAN. Thank you, Doctor. The committee will look into your recommendation regarding the social service agencies, and we

will probably be requesting more information from you, including the book that you have recommended to the committee.

I turn now to recognize Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

I want to commend certainly all of our witnesses, and definitely these three, for the power, of their testimony. This is an illustration of what can be gained out of these hearings, particularly field hearings where you come down to the grassroots. Our chairman is a gentleman who has been in Congress for something more than 30 years—20 years. I know that you have been on the select committee for an awfully long time because you have risen up to the chairmanship, and he replaced Senator Claude Pepper. In any case, the point I was trying to make is that he has learned a great deal here today, in spite of all his years serving on this committee. And this is an indication of how very valuable this testimony is.

I would ask Dr. Winchester, you testified that in a general hospital in a population slanted toward a high percentage of aged, drug and alcohol does not appear as a primary diagnosis. Should it in some cases appear as the primary diagnosis?

Dr. WINCHESTER. Yes. Unfortunately, the medical record librarians who keep our records have to assign every patient's diagnosis to, No. 1, a primary diagnosis, and then you have a whole raft of secondary diagnoses. The primary diagnosis is the one that is very visible and socially acceptable, a hip fracture, pneumonia, heart attack. Doctors are emotionally unwilling to tab as many people with a primary diagnosis of alcoholism, drug abuse, and so they are very willing to put down some of the other things that are the specific things that get them to the hospital such as a fracture, automobile accident that occurred when they are drunk or overusing drugs; so that becomes the primary diagnosis. It is very hard to then extract from the medical records the incidence of the secondary diagnoses which are really in effect the true beginning of the problem.

Mr. BILIRAKIS. So the true beginning of the problem is sometimes never addressed or at least not addressed adequately.

Dr. WINCHESTER. Not addressed in the medical record files. It will be addressed by the physician taking care of the patient if he is cognizant of these problems. Sometimes the patients do not even tell them the problems and some doctors are so busy they do not even ask if they are taking medicine, but most do.

Mr. BILIRAKIS. If we had a specialty, and obviously medical students would have the right to choose their specialty, family medicine is I think head over heels the No. 1 specialty, should be looked up on as that, but basically what I am saying is if we had such a specialty is there a greater likelihood that alcoholism might become more of a primary diagnosis because of referrals to someone who is better able to handle the problem. It seems—I gather from your testimony that much of the failure to use that as a primary diagnosis is psychological on the part of the doctor, they do not really want to treat an alcoholic.

Dr. WINCHESTER. Unfortunately some physicians are human.

Mr. BILIRAKIS. Well all of us are.

Dr. WINCHESTER. And being human, they are susceptible to most of the frailties of being human, which is having emotions. And in

our culture today, alcoholism and drug abuse are still not emotionally accepted categories. You do not usually talk about those topics any more than you talk about the incidence of primary syphillis in a group such as here, it is not done. Doctors are human and so they will sometimes fix things so that the hip fracture looks more important.

I would like to comment to the chairman that in the last 10 years there has been an increasing number of family physicians graduating and certainly that is true from the west coast, the great middle part of the country. I know that I enjoyed receiving my fellowship in the American Academy of Family Physicians in your home city.

The CHAIRMAN. I am glad to hear that, Doctor, because just recently I talked to a young man that I helped at the very beginning to go to college and now to medical school. He comes from the same area of the city that I do, from the poorest community that one can possibly find any place. He was telling me he was going to specialize. He told me the specialty and I asked why he wanted to specialize in that field. He said because there is a lot of money in it.

I felt disappointment in seeing this young boy grow up to become a doctor in a specialty just because it gives him a lot of money. I thought he was going to say to me "I want to go into this specialty because I want to come to my own community to help, to help those people in need." But that was not his objective. This is why I brought this matter up of the family physician. I compliment you and others that are in this field because you are doing a lot of good for humanity, and I am glad to hear that there is an increase of people being trained in family medicine.

I thank you very much. Any other questions?

Mr. BILIRAKIS. I have nothing else.

The CHAIRMAN. I would like to thank the three of you for your very excellent testimony.

The next panel is being made up of the following witnesses: Mrs. Mary Ann Morck, Mr. Morton Cohen, and Mr. Robert Myers.

Ms. Morck is director of community education, Mr. Cohen is a senior pharmacist, and Mr. Myers is vice president for pharmacy services.

Now we are going to hear testimony from the pharmacists' point of view. I would like to ask Ms. Morck to start off.

STATEMENT OF MARY ANN MORCK, DIRECTOR, COMMUNITY EDUCATION, OPERATION PAR, INC., PINELLAS PARK, FLA.

Ms. MORCK. I have a prepared statement that is in front of you but as I sat here and listened to the other presentations, it is hard for me to stick to my prepared statement.

The CHAIRMAN. Without objection, your prepared statement will be included in its entirety in the record, and we ask that you summarize it in your oral presentation.

Ms. MORCK. What I would like to do now is tell you a little bit about what Operation PAR is, and why we are involved with the elderly in the mismanagement of medication.

Operation PAR is a comprehensive substance abuse agency. When we tell people that we are involved with the elderly in the mismanagement of medicine, they look at us as though we have three heads because they tend to think that substance abuse issues really only deal with people 35 and younger.

What we have found, and Operation PAR has been around for some 13 years and is one of the substance abuse agencies in the State, we have been involved in elder/ed as we call it, since 1979. Our elder/ed program is comprised of a unique approach dealing with mismanagement of medication. One thing we take very seriously is that the elderly problem with drugs and medication should be or at least can be an easily dealt with problem than the use of illegal drugs widely used in our country. It is a legally sanctioned and controlled system through pharmacy and rules of medicine and it should be easy for us to attack.

PAR's approach has been that of information sharing and that of mismanagement. What we do is basically go to organized places where senior citizens gather, either meal sites, neighborhood senior centers, or retirement centers upon request of either department of health service on aging or at the request of an organization such as a retirement community, and talk about the issues surrounding the mismanagement of medication. We prepare them to make a doctor's meal at a senior site. Does that mean they take the medicine once a day or two times a day? Those are the issues we deal with when we go out to see the elderly.

In the course of a year, we reach close to 3,700 elderly people with one staff member who goes out and talks with the elderly daily throughout the year at senior sites.

Without getting into all the statistics that you have heard from other expert witnesses, our approach and what we'd like to provide is a starting out point for the Select Committee on Aging, there are agencies that deal with the aged, there are people who provide congregate meal sites where people come together to deal with their isolation problems. Our approach is more preventative and more consumer education oriented.

What we propose as a good starting off point to deal with the problem from a comprehensive scope, is to coordinate alcohol and drug agencies and people who hold alcohol and drug substance abuse education licenses throughout the country with the people that deal directly with the aged. Bring those people together to provide the expertise that we have in substance abuse education with the people that can get to the elderly. We need to get those people together quickly to develop curriculums and programs much like ours, low staff intensity, very little cost, and provide that service to them. The paths to the elderly are without end.

[The prepared statement of Ms. Morck follows:]

PREPARED STATEMENT OF MARY ANN MORCK, DIRECTOR, COMMUNITY EDUCATION, OPERATION PAR, INC., PINELLAS PARK, FLA.

Operation PAR is a comprehensive drug abuse education, prevention and treatment program. Drug misuse and abuse affects all age groups. Most drug abuse education, prevention and treatment programs traditionally have focused on adolescents and young adults. However, the problems of medication misuse among older Americans are serious and complex.

The fastest-growing segment of the population in the United States is made up of people in this age group, over 95 percent are living in the community and monitoring their own health care. Drug abuse among the elderly is or at least should be an easier problem to address than the widespread use of illicit drugs by other segments of the population. The elderly drug abuse problem involves a legally sanctioned and controlled distribution system. Their self-medication includes the administration of prescribed drugs (carrying out a physician's order without direct medical or nursing supervision), and the selection and use of non-prescription drugs. Often, a good deal of this self-medication is carried out in an uninformed manner, resulting in unsafe or ineffective administration of the medicine. In a 1962 study of medication errors made by elderly, chronically ill ambulatory patients, 59 percent of the study population was found to be making one or more errors in self-medication; 26 percent made potentially serious errors (Schwartz, et al., 1962).

Medication misuse is a negative health behavior that exists among adults of all ages, but the older person is more likely to experience problems resulting from inappropriate drug use. Although aging is not a disease, the aging process invites chronic conditions and diseases that require medication.

Physiological factors contribute to the older adult's increased risk of developing drug side effects and adverse reactions (Burnside, 1976). The rates of absorption, distribution, metabolism, and excretion of drugs tend to decrease with advancing age. The resulting difference in drug activity in the older adult's body yields a different therapeutic response than in the younger adult. Increasing age may predispose to hyperreactivity or hyporeactivity (Lasagna, 1956). Either possibility contributes to an increased incidence of adverse drug reactions among the elderly. In addition, the reserve capacities of the organ systems are decreased. It is therefore more difficult for the aged body to adapt to stress (such as that resulting from an adverse drug reaction), and a longer time is required for a return to equilibrium (Schwab, 1973).

Complicating the problem is the lack of specified geriatric drug doses. Most experimental data on drug metabolism are obtained from adults in their mid-twenties (Gorroed, 1974). There is a pediatric dose for most drugs, or a formula such as Young's Rule or Clark's Rule (Musser and O'Neill, 1969) for finding the dose. No one has devised similar general guidelines for geriatric prescribing. The normal adult dose of a drug is not always appropriate for elderly patients.

Limited dexterity and decreased visual and hearing acuity are present to some degree in most older adults (Schwab, 1973). These impairments can create obstacles in opening medicine containers, reading labels or distinguishing between pills, and hearing instructions. Many of the elderly live alone or with other older people, and there may be no one available to compensate for these kinds of physical deficits.

Medication is a valuable therapeutic tool for the care of the elderly. Research indicates that as a group, the elderly compose approximately 9 percent of the national population, yet consume approximately 25 percent of all prescribed drugs. In Pinellas County, the elderly constitute 34.9 percent of the total population. The relatively high rate of medication use in conjunction with the percent of the total population along with the dysfunctional aspects of the aging process place the elderly "at risk" with respect to the potential misuse of prescription and over-the-counter medications.

In 1979, as a result of interest in drug mismanagement behaviors of the elderly, Operation PAR began the Elder/Ed Program. The goals of Operation PAR's Elder-Ed Program are:

To inform the public of possible reactions to medication misuse

To answer questions concerning the correct method of using both prescriptions and "over-the-counter" medications

To develop a network of informed people who are willing to pass on information to others regarding the correct methods of using medications

As the program developed, it became evident that no systematic attempt had been made to identify the medication/drug use needs of Pinellas County elderly, nor was any national data available. An initial survey was conducted to attempt to gain insight into the medication concerns and behaviors of the elderly. The initial research effort completed by PAR was crude. PAR redesigned the initial survey instrument to provide more comprehensive information into the medication practices of Pinellas County elderly in 1983.

Measuring the severity of the medication misuse problem among the elderly is a complex task. The survey was designed to secure information regarding the demographic characteristics of the respondent, his/her general health, prescription drug use, as well as the use of over-the-counter medication. In order to make the survey as easy to complete as possible, all questions required a forced choice response. The forced choice format enabled participants to check the appropriate response with an

option to explain a notation of "other". The instrument was presented in large bold face type on brightly colored paper to ease any reading problems.

The target population was identified as Pinellas County residents 60 years of age or older. There were a total of 356 survey participants. Survey participants were drawn from various parts of the county. Despite the relatively higher rate of use of medication among the elderly, there is a hesitation to equate medication and drugs. In the development of the survey, care was taken to use the term "medication" instead of "drugs" whenever possible to reduce any anxiety of the elderly respondent.

The survey focused upon prescription drug use, use/abuse of "over-the-counter" medication, a review of unsafe medicating behaviors, and identification of "at risk" factors relating to the elderly and drug use.

The results of the 1983 Elder-Med survey indicate the following:

1. A large percentage (68.4 percent) of the elderly resident population are consumers of prescription medicine.

2. Pinellas County elderly are not only consumers of prescription medicine, but almost half (49.1 percent) of the population indicate use of over-the-counter medicines.

3. 44.5 percent of the elderly population frequently use over-the-counter medication in conjunction with prescribed medicines with little or no consultation with their doctor.

4. Approximately 83.1 percent of the elderly population engage in at least one unsafe medication practice.

5. Over half (56.3 percent) of the population indicated moderate to high levels of involvement in unsafe medication practices.

6. The risk of a medication error is increased in relation to the total number of risk factors that can be ascribed to a respondent. Almost 10 percent of the survey respondents' risk scores fell in the high range. An additional 47 percent cited a moderate risk level.

7. Finally the data suggest that the majority of the elderly engage in unsafe medication behaviors and are "at risk" of medication mismanagement.

The objective of the elder-med study was to identify and synthesize information on the use and misuse of prescription and over-the-counter drugs among the elderly. Study results indicate that a concern for the high rate of medication use and mismanagement among the elderly is warranted. Underreporting is common to all age groups on sensitive subjects and is an expected reaction in self-report inquiries. Thus, the true dimensions of the drug use/misuse practices of the Pinellas County elderly may only be estimated from the data.

However, the elder-med survey results serve to reinforce the need for medication management services for the elderly. Education and prevention efforts should be concentrated on the dynamics of medication use/misuse in relation to the aging process. Another area for service development would be to make the general population sensitive to the potential dangers of dealing with the aged through medication.

Consumer education should be the main emphasis of a drug education program for older adults. In a program designed to prevent the inappropriate use of drugs, professional education is also necessary. Doctors, nurses, and pharmacists need to be made aware of the special problems of medication use among the elderly. More research in the areas of drug-drug and drug-food interactions is needed, and greater efforts should be directed toward developing geriatric doses for drugs. In addition, health professionals need to devise more efficient ways of disseminating drug information in a quick and comprehensive manner.

Group health education is one approach to medication problems. Education can help to create positive health behaviors; early intervention of another kind is often needed to correct negative behavior. A Drug Awareness Center for the elderly—including consumer and professional education, a drug information hot line, medication counseling, crisis intervention, and health referral and follow-up—could provide a more comprehensive program. This is not a new idea. We are suggesting that the principles of drug education and counseling for young people be applied to an older age group.

A drug awareness program is not designed to discourage or encourage drug use, but to stress the appropriate use of drugs when they are necessary. People over the age of 65 are a high-usage, high risk group of drug consumers, and group health education can help them to more safely and effectively manage their medications.

Nationally coordinated approaches for dealing with the problems of medication misuse among the elderly have yet to gain support. There needs to be cooperation between recognized elderly service providers, health care professionals and substance abuse prevention, education and treatment programs. Coordination of the ef-

forts of all three disciplines will provide the elderly the most comprehensive service package available.

Operation PAR, as a comprehensive substance abuse education, prevention and treatment agency, is committed to the needs of the elderly.

Operation PAR has provided elderly medication misuse prevention and mismanagement services for the elderly on a systematic and comprehensive basis since 1979. We feel as though our experience provides an excellent background from which to make the following recommendation.

We propose a program of prevention and consumer education. Prevention efforts will be aimed primarily toward providers of health care services who directly interface with the elderly (e.g., nurses and mental health specialists). Such professionals, as well as ancillary care providers (e.g., nursing home staffs, meals-on-wheels providers and community center staffs), will be given specialized in-service and workshop training. Consumer education services will be provided directly to the elderly person and to elderly service providers. Presentations on the proper use of medications and the appropriate management of drugs will be made before existing groups such as Neighborly Centers and retiree organizations. A wide array of materials for consumer education in the area of medication management has already been developed.

Given the parameters of limited funding, this proposal would provide maximum consumer and service impact with minimum expense. Development of such a program could be effected by combining the resources of area agencies on aging and state recognized substance abuse professionals. Model programs and materials could be developed quickly and decimated through drug education professionals.

Such services would directly reach several hundred thousand elderly consumers as well as health care providers who contact additional consumers. The anticipated result of such coordinated service and quick response would be the reduction of the inappropriate use of medications among the nation's elderly.

The CHAIRMAN. Mr. Morton Cohen, please proceed any way you desire.

STATEMENT OF MORTON COHEN, R. PH., SENIOR PHARMACIST, FLORIDA MENTAL HEALTH INSTITUTE, LUTZ, FLA.

Mr. COHEN. Thank you, Mr. Chairman, Mr. Bilirakis. Before I go into my statement here, I would like to preface it with my feelings. I feel like the man who has been asked to reinvent the wheel. All the good people prior to myself that were here before you have gone through my papers or else they have contacted me or have used my ideas for the past 10 years in this area here.

I feel gratified in that respect. So with that, I will start off, and I will add to my paper just slightly, but I will follow it almost to a T, sir.

Ideally, the older person goes to the physician, presents his or her symptoms, and is given a prescription for an appropriate medication. The older person then goes to the pharmacy and the prescription is filled by the pharmacist. The medication is then taken appropriately and the symptoms are alleviated or eliminated. True or false? Things can go wrong at any one of these stages. The older person, first of all, represents a challenge to the physician. The physician's prescription may be equally challenging to the older person. The misuse we are dealing with may be person related or doctor related.

The person-related misuse is sometimes tied to economics. The older individual may choose from among prescriptions because it is financially impossible to have them all filled at one time. How many times have you been handed prescriptions, three or four at one time, and gone to the pharmacy and have held them in your hand and made the decision whether or not to have this one filled or that one filled, without checking with the pharmacist to see

which is the important prescription that should be filled at this time. Also, have you ever asked the pharmacist, may I get one-half of this prescription filled now and one-half later.

For the same reason older people may substitute over-the-counter medications for prescribed medications and cost is often the basis for medication swapping. Drugs prescribed for mental health—and by the way, I am basically a mental health pharmacist—can alter the way a person feels and are sometimes taken apart from prescribed times in order to feel better or to escape problems. However, noncompliance is often unintentional and occurs because of forgetfulness or confusion.

The response of the geriatric to medication differs from that of the younger population. You notice that I state mostly medication, I dislike the word drugs. Drugs denotes street drugs as far as I am concerned. You are taking medication, prescribed medication. although even the basic aspirin is a drug, but still medication is what we are talking about. We are talking about the legal misuse of medication or the misuse of legal medication. In the older persons, the enzyme systems, the metabolic processes, the liver function deteriorates and becomes sluggish in later life. The ability to absorb, distribute, degrade, or eliminate drugs is interfered with, and the susceptibility to various side effects and toxic reactions is enhanced. There is a decrease in absorption because the gastrointestinal tract of the elderly has fewer active cells and a decreased blood flow, thereby reducing the enzymes needed to transport the medication. This yields a slower absorption rate. Therefore, the physician who is at the apex of all the problems and is responsible, should be very careful in the dosage buildup problem and not overshoot the optimum level and arrive at a toxic level.

The safest approach is to start off low and gradually build up the dosage to a point of clinical efficacy. Building up slowly is essential but it is equally important not to undertreat. Initially, the total daily dose should be divided and spread out over the day, with dosages adjusted upward within a few days if the target symptoms have not shown adequate response. We give medication and we expect a response. And what I am saying in essence is we build slowly and go up with the dosage until we see the response that we want, and the response for each individual is different, it is not the same. That marks the difference between an over-the-counter medication, which has a dosage two or three times daily or check with your physician or a prescription drug which has no real dosage, it has an average dosage that is set by the USP but it does not have the dosage for that individual. The dosage is set by your physician depending on the situation, depending on age, your weight, your physical being.

Once the optimum dose has been established and the target symptoms are responding, then you can gradually shift the dose schedule to a single bedtime dosage that allows improved sleep by taking advantage of the sedative properties of many medications. And this we have found to be very true. We have found that most of the medication that is used, and I apologize for not speaking directly to you, sir, most of the medication that is used today can be used with the exception of antibiotics, can be used in a single dosage pattern so that it is cheaper for the elderly or for the

person using it because the cost of the medication is not in the cost of the drug itself, but in the manufacturing process. So that a larger dosage, let's say a 150 milligram dosage of a medication is not three times the price of a 50 milligram. Therefore, the cost is lower. It also gives better regime usage and conformity and the individual is not tied down to taking it during the day, so that they also get the benefit of the sedative action, sometimes it is unwanted during the day or it is labeled "Do not use in case of machinery or other vehicles are used." When they wake up their mind is free and clear and they have the side effect which is helpful.

Since the elderly have a high incidence of physical illness—cardiovascular disorders, respiratory problems, liver or renal dysfunction, cancer, diabetes, or malnutrition—the use of psychotropic drugs may sometimes be contraindicated because of interaction. The physician must give careful physical examinations before starting treatment, and treat the medical problems first. Lab reports and drug treatment plans are important but they are not a substitute for listening to the patient. The patient knows exactly what is wrong. It reminds me of the story of the patient who went to the dentist and the dentist said which tooth hurts and the patient said you tell me, you are the dentist.

We stress highly to avoid polypharmacy; that is the use of many, many drugs. Studies show that in elderly patients who are on multiple drugs, 12 to 13 or more, and we have a classic example at the University of Florida of a patient coming in on 40 drugs, their mental symptoms improved merely upon the reduction in the number of drugs.

In studies dealing with medication compliance in the elderly, the most frequent error was omission of medication, followed by lack of knowledge about medications, use of medications not prescribed by a clinician, and errors of dosage, sequence, or timing.

We believe that the following principles should be enforced in geriatric prescribing by the physician:

One. Strive for a diagnosis prior to treatment.

Two. Careful drug history, at least the past 6 months.

Three. Know the pharmacology of drugs prescribed.

Four. Use smaller doses to begin with and titer to optimum efficacy and response.

Five. Simplify the therapeutic regimen, if possible, a single bedtime dosage.

Six. Review regularly, 1 month preferred, drugs used and discontinue if not needed.

Seven. Remember that drugs may cause illness.

In studies done at Shands Teaching Hospital at the University of Florida, 5 percent of all hospitalizations were caused by drug reactions. Most of those hospitalized were elderly. One out of two elderly persons misuses drug prescriptions—prescription drugs.

The elderly represent 10 percent of the Nation's population and consume 25 percent of all drugs. They consume 40 billion doses of the medication annually.

Many people who purchase so-called patent medicines over the counter, or OTC as we call them, from their convenient pharmacy do not think of them in the same light as prescription medication, but they are all medications that react with each other, they poten-

tiate each other, they negate each other, sometimes with fatal or near-fatal results.

The doctor's decision to select a particular medication is based on the information the patient gives, on his or her knowledge of medicine and the patient. The following is a list of items that all clients, or patients, young or old, should bring to the attention of their physician:

One. Tell the doctor what is wrong with you and how you feel and what the symptoms are.

Two. Tell about other doctors who are treating you now or who have in the past. Your present physician may want to talk to them.

Three. Tell him about all the medication you have at home. It is good sometimes to take them with you to the office so you do not have to rely on memory, or write them on a card with date, medication, regimen, and refills.

Four. Tell the doctor how the medications he prescribed for you performed, the good or bad actions.

Five. Ask the doctor about the good effects you might expect from the medications.

Six. Ask about the other effects that might follow and if you should get in touch with him if they should occur.

Seven. Request that the regimen be as easy as possible to follow.

Eight. Remember, only a doctor can prescribe medications. It is unwise to take medications from your family or friends. The medication which helped them may harm you.

In closing, the pharmacist is truly knowledgeable about medications. It is his professional duty to see that the patient gets the exact medication the doctor has prescribed and to see that he or she has the proper instructions on how to take it. The key to this is the label. Everything the patient needs to know is printed on the label; the name of the medication, the manner in which it is to be taken, the special hazards involved, the name of the doctor, the name of the pharmacy, and whether it can be refilled without a new prescription.

The elderly patient should be advised to:

One. Read the label. If the print is too dim or too small ask the pharmacist to retype it in larger type.

Two. If the directions are not clear, ask the pharmacist to explain them.

Three. Ask the pharmacist's advice before you buy any over-the-counter medication. It may react with your prescribed drugs.

Four. Ask the pharmacist before you take any medication left over from prior prescriptions. It may be out of date or react unfavorably with a newly prescribed medication.

Five. There are many advantages to using the same pharmacy. A distinct advantage is that the pharmacist can keep a drug profile of regular customers and can readily tell if any added medication is contraindicated.

Six. The label is the key to the drugs. It contains the three rights of taking medications: The right drug, the right amount, and the right time.

Seven. Remember the hazards of mixing medications with alcohol, cigarettes, and coffee, which can be fatal.

Eight. The use of pill boxes that are not labeled is also hazardous.

Thank you.

The CHAIRMAN. The chair will now recognize Mr. Robert Myers. Mr. Myers, if you would like, you can submit your testimony in its entirety for the record and you may summarize, or proceed in any way that you may desire.

STATEMENT OF ROBERT L. MYERS, VICE PRESIDENT FOR PHARMACY SERVICES, JACK ECKERD CORP., CLEARWATER, FLA.

Mr. MYERS. Thank you, Mr. Chairman, Congressman Bilirakis.

I am the vice president of pharmacy services for the Eckerd Drug Co. Eckerd Drug operates 1,370 drugstores in 15 States. Our pharmacies are located primarily in the sunbelt from Texas to Florida and located up the eastern seaboard into Delaware and New Jersey. Our company is one of the Nation's largest providers of prescriptions to the American public.

Through the years our company and our pharmacists have supported public and private efforts to better inform consumers on health care and the proper use of drugs and prescription medication. We have been involved in programs which seek to curb the misuse and abuse of drugs. We recognize and encourage this committee's review of the real and potential problems associated with misuse and abuse of prescriptions as well as over-the-counter medications with our senior citizens.

To deal with the need for information on drug therapy, we have targeted our programs towards providing important basic information. For example, recognizing the need the pharmacists the physician or the patient have for complete prescription information we began using and distributing the personal prescription record. This handy, credit card size form provides basic drug information on the patient in lay terms including the date of the prescription, the prescription drug name, its number and its use. Since most senior citizens we have found use more than one doctor or pharmacy, this traveling record can help reduce duplicating prescriptions or drug therapy by different medical practitioners.

In addition, our health line phone-in program provides easy access to up-to-the-date information about specific health and personal care subjects such as those dealing with cough and colds, digestive aids, eyes, first aid, skin care, vitamins, pain preparations, foot care, generic drugs, and many others. This program will be expanded to most of our stores to provide pamphlets on some of the most frequently requested information by our customers in our pharmacies.

Each day our pharmacists monitor the prescription and OTC purchases for their customers. They help protect duplication in therapy when the patients different doctors prescribe for different ailments. In addition, to assist senior citizens we include warning labels, option nonsafety caps, and strong reminders in our advertising and promotion on the pitfall of transferring medication or using alcohol with their medication.

We are upgrading our ability to check patient utilization and drug interactions such as drug-drug, drug-allergy, and drug-chronic

condition by installing computers in our pharmacies. Last, our pharmacists are available to discuss OTC medications with the patient and do so on a daily basis to insure that products are used as necessary.

In 1980, the leading causes for death in senior citizens included heart disease and cancer. We have targeted special programs to address these issues. While we have an active blood pressure education program ongoing in our stores, we have also made patient self-monitoring a reality with the installation of free automatic blood pressure monitoring equipment.

Probably the biggest inroads we have made in drug abuse in recent times has been our conscientious decision to eliminate the drug methaqualone, commonly known by its trade name Quaalude, from our drugstores. Approximately a year and a half ago we banned that drug from our pharmacies. Information that we had received from Dade and Broward County medical examiner and the coroner's office had determined that that drug was involved in many accidents caused by alcohol and the drug methaqualone. The combination of that drug and alcohol is very lethal. We have banned that product from our stores and have been very active in introducing legislation in a number of States where that drug no longer can be prescribed by the physician. Also, recently in the last several weeks, the last manufacturer of that drug in the United States has ceased to produce the product and it will no longer be available to the public.

We will continue to monitor the needs of the senior citizens through round tables and discussions with our pharmacists and other store employees to insure that we are responding to the changes not only in the health care system but in the needs of our customers. At Eckerd Drug we will continue to improve and develop programs to better serve our senior citizen customers.

Thank you.

[The prepared statement of Mr. Myers follows:]

PREPARED STATEMENT OF ROBERT L. MYERS, VICE PRESIDENT, PHARMACY SERVICES, ECKERD DRUG CO., CLEARWATER, FLA.

Mr. Chairman, Members of the Committee. I am Robert Myers, Vice President of Pharmacy Services for the Eckerd Drug Company. Eckerd Drug operates 1370 drugstores in 15 states. Our pharmacies are located primarily in the sunbelt from Texas to Florida and located up the eastern seaboard into Delaware and New Jersey. Our company is one of the nations largest private provider of prescriptions to the American public.

Through the years our company and our pharmacists have supported public and private efforts to better inform consumers on health care and the proper use of drugs and prescription medication. We have been deeply involved in programs which seek to curb the misuse and abuse of drugs. We recognize and encourage this Committee's review of the real and potential problems associated with misuse and abuse of prescriptions as well as over the counter medications with our senior citizens.

While the elderly do use more prescription drugs than other individuals, it is important to note that with increasing longevity which is at least in part due to new, sophisticated drug therapy there are many people benefiting from a more healthy life. In our opinion most senior citizens are properly complying with their drug therapy; however, the problems associated with better drug therapy and longer life spans will also bring with it the problems under review by this Committee.

Since we operate a number of pharmacies in Florida which has a senior citizen population of over 17 percent, we have had a better opportunity than most pharmacies to serve and work with a large, diverse senior citizen population. Through the

years we have sought to provide high quality prescription services which give the patient exactly what the doctor ordered at an affordable price. Our highly skilled professional pharmacists offer the full spectrum of pharmacy services and have sought to better inform consumers through individual consultation and promotion of health care prevention.

To deal with the need for information on drug therapy, we have targeted our programs towards providing important, basic information. For example, recognizing the need the pharmacists, physician or patient have for complete prescription information we began using and distributing the Personal Prescription Record. The handy, credit card size form provides basic drug information on the patient in lay terms—the date, prescription drug name, number and use. Since most senior citizens use more than one doctor or pharmacy, this traveling record can help reduce duplicating prescriptions or drug therapy by different medical practitioners.

Our Health Line Phone—In Program provides easy access to up to the date information about specific health and personal care subjects such as those dealing with cough and cold, digestive aids, eyes, first aid, skin care, vitamines, pain preparations, foot care, generic drugs, and many others. This program will be expanded to all of our stores to provide pamphlets on some of the most frequently requested information by our customers in our pharmacies.

Each day our pharmacists do monitor the prescription and OTC purchases for their customers. In most stores the pharmacist knows people coming into his store and can monitor their compliance with therapy just by the time that they come in for a refill. They also can help protect duplication in therapy when the patients different doctors prescribe for different ailments. To assist senior citizens we include our warning labels, optional safety caps, and strong reminders in our advertising and promotion on pitfalls of transferring medication or using alcohol with their medication.

We are upgrading our ability to check patient utilization and drug interactions such as drug-drug, drug-allergy, and drug-chronic condition by installing computers in our pharmacies. Last, our pharmactists are available to discuss OTC medications with the patient and do so on a daily basis to ensure that products used are necessary.

In 1980 the leading causes for death in senior citizens included heart diseases and cancer. We have targeted special programs to address these issues. While we have an active blood pressure education program on-going in our stores, we have also made patient self monitoring a reality with the installation of free automatic blood pressure monitoring equipment. Today a growing number of physicians have their patients come to our store for self monitoring of their blood pressure. This saves time and also avoids needless charge for a physician visit but also directly involves the individual in complying with his therapy.

But the best received programs we have conducted deal with specific disease testing. The most recent has been aimed at cancer through a free colon/rectal screening program. This highly successful program, like prior ones dealing with diabetes, blood pressure, flu, etc., in every area we operate bring hundreds of gratifying letters—primarily from senior citizens like this one: "I want to thank you company for your part concerning the hemocult test. I, am an active 71 year old who thought I was in the best of health. I sent the test in just to ensure myself it was true. In a few days a letter arrived from the hospital informing me that I might have a problem. In fact test and x-rays showed a small spot. The biopsy proved the spot was positive. The doctor performed surgery a few days later. I am now feeling stronger every day. I am most gratified to those who made the test possible. Since this was discovered early I need take no treatments. God bless you. An Eckerd customer." Responses like that encourage us to look for more ways to help.

In terms of availability we do operate on longer store hours in most community pharmacies. Our pharmactists are available not only for prescription but over the counter consultation and they do discuss patient questions and problems and concerns about drugs, their misuse and their needs to see a physician.

Operating in Florida we have long recognized the limits of senior citizen's income. For that reason years ago we instituted a program which reduces the cost of prescriptions to our senior citizens. We also as part of the generic program, have made a special effort to get those drug products that are available from our reputable manufactures that can produce 30 to 50 percent savings to senior citizens.

We continue to monitor the needs of senior citizens through round tables and discussions with our pharmacists and other store employees to ensure that we are responding to the changes not only in the health care system but in the needs of our customers.

We do know that in order for any program to work, whether it deal with better health care or misuse of drugs that there must be incentives both for the senior citizens as well as provider. Whatever program is involved there must be incentives that encourage senior citizens as well as other consumers to stay well and identify and choose efficient providers.

More programs aimed at the promotion of awareness of healthfulness, benefits of drug therapy, disadvantages and problems associated with drug misuse must be made available to the senior citizens. These coupled with good incentives will provide a more healthy living environment.

At Eckerd Drug we will continue to improve and develop programs to better serve our senior citizen customers.

The CHAIRMAN. I thank the three panelists for their very interesting testimony. I for one have learned a great deal. I know now that I can go to a pharmacy and only get one-half of my prescription. I never knew that before. I thought if the doctor said you had to take a prescription of 12 or 15 or 24 pills—as I sometimes do when I have a cold—that I had to buy all the pills. Now I am told that I can buy only one-half of that. I welcome that information as I am sure that everyone here today welcomes that information.

The other thing that I have learned is some of the positive things that your organization is doing. I also learned that perhaps this committee can start thinking about a change in the title of these hearings. I think that we should call these hearings A study in the Use of Alcohol and the Misuse of Medication Among the Senior Citizen Population. We should avoid the drug and alcoholism side of it, even though we will be addressing ourselves to the same subject matter. Then we can have people, like the two ladies that testified at the beginning, tell us what the real problem is, and then the experts like yourselves and the others on the panel can tell us what we can do as a committee. Together with the recommendations that have been made today, I think the committee is in a better situation now to make a determination. As I said, this is just the beginning of a series of hearings on this subject matter.

I want to thank the witnesses. You have all done an excellent job. You have pointed us in the right direction.

I want to again thank Mr. Bilirakis. I also wish to thank the staff and the center. Above all I want to thank every senior citizen that is here at this hearing. Without you, we would not have a successful hearing. There is no doubt about that. I appreciate you sharing with the committee this vital information. You and I together can work toward solving the situation because I, as a senior citizen, am interested in this problem. As chairman of this committee, my interest goes even farther than that. But we cannot do a thing in Congress unless we have the support of people like yourselves. You have shown that support by your attendance and I thank you very much.

I am not going to ask any questions of the witnesses because I am supposed to leave now. I will then pass over the chairmanship to your own Congressman, who will hear from his own constituents. I thank him again for insisting that I come to this district. He did insist, and I am glad that he did. Thank you very much.

Mr. BILIRAKIS. Thank you, Mr. Chairman. He has passed the gavel to me, but he is still Mr. Chairman.

I would like to say that sometime late in the winter or early in the spring, either in February or March actually to be more specif-

ic, we will hold—the full Aging Committee will hold another hearing in our district on Alzheimer's disease and the chairman has agreed to come back for that one and hopefully he will be able to stay longer next time and partake of our good climate, although I guess Los Angeles certainly rivals it.

I have asked the county commissioner from Pinellas County, Gabe Cazares, who is the chairman of our ad hoc committee helping us to develop agendas for these hearings, helping us to come up with names of prospective witnesses and that sort of thing, to chair the balance of this hearing. We are continuing our formal hearing. I will excuse the witnesses at this time and also commend them and thank them so very much.

For the remainder of our session we are going to 1 minute. Now the Speaker of the House gavels us quiet when we hit that 60 second mark and so I am going to ask Mr. Cazares to gavel you when you hit the 60 second mark. I am hoping that your comments will be in point with the subject matter of this hearing or maybe general older-American type problems if you will. They will become a part of the Congressional Record so speak now or forever hold your peace, so to speak.

I would ask you to go to either one of the two mikes because otherwise the television cameras and radios and what-not will not be able to pick you up. So just start lining up at that mike back there and this mike here and the chairman will call upon you, he will look at his watch, give you 60 seconds and no more and then we will recognize someone else. We would ask that you also identify yourself.

Mr. Chairman, Gabe Cazares.

Mr. CAZARES. Thank you, Congressman. We will start with this lady.

STATEMENT OF RUTH PUGH

Ms. PUGH. My name is Ruth Pugh and I would like to say that meetings such as this bring alcohol and drug abuse out into the open. Public education to the effect that alcoholism is a disease, not a disgrace, might help reduce the related social stigma and let other people ask for help.

Mr. CAZARES. Thank you.

STATEMENT OF DR. NIKOLAUS

Dr. NIKOLAUS. A patient this past week brought in a sign I meant to bring with me today but I left it at home, but I thought it was very appropriate. It said, "Old Age isn't for sissies." I think this problem is but a part of a total individual problem and we need to keep it in perspective. The suggestion was made earlier that we perhaps should have specialists. I plead we do not get and do not need specialists in this area, we need to teach all medical students because all medical students, other than pediatricians, are going to see this problem. So, it needs to be taught to all.

FAMILY PHYSICIANS

The American Academy of Family Physicians is a going group, 54,000 strong at the present time, 17,000 are students and resi-

dents. We are trying to get a very extensive training program, we hope eventually to encourage 25 percent of graduating medical students to become family physicians.

I have one more point here. DRG's is the way hospitals are reimbursed at the present time, with DRG's—diagnostic related group—we are going to have less and less alcoholism and drug abuse being included as a part of the diagnosis, at least the major part, because the major part of the diagnosis will be that that is reimbursed the most.

Mr. CAZARES. Thank you, Dr. Nikolaus.

STATEMENT OF HOWARD BRUBACH

Mr. BRUBACH. My name is Howard Brubach, I am from west Pasco County, I am the president of WESPAC, that is an umbrella organization encompassing between 65 and 70 civic organizations here in west Pasco. I have been very, very pleased with what I heard here today and although this has not been brought up as a regular agenda item in our organization, I believe that I can safely take a presidential prerogative at this time and guarantee you our support in these hearings and what we hope that they will produce.

Thank you very much, Congressman, for having these types of hearings because they are very good for everyone.

Mr. BILIRAKIS. Thank you, Mr. Brubach.

STATEMENT OF ROY ROGERS

Mr. ROGERS. My name is Roy Rogers—no laughing. I have listened with great interest today because I am a 12-year-recovering alcoholic. I would like to suggest to the committee that they contact the following people, the addresses are readily available and I will give it to you afterward: Dr. Norris, who is the chairman of the board of General Services Organization of Alcoholics Anonymous, he is not an alcoholic, he is an M.D.; Dr. Vernon Johnson, the director of the Johnston Institute in Minnesota; Dr. Max Weisman, director of Merrill Mental Hygiene; Mr. Lou Boudreau, the director of School of Alcohol Studies at Rutgers University; Dr. Jelnick, who is known as the father of the concept of the disease of alcoholism. His address is somewhere in the world, you have to contact ADA, Alcohol and Drug Problems in America to find out where he is.

Second, I would like to see this because I have a lot of friends who are in the same age bracket and I try to educate them but you can only suggest, you cannot push, I would like to see a fluorescent label go on all CNS drugs that reads something similar to this: Warning. Do not consume alcoholic beverages or other CNS drugs while on this medication unless advised by your physician.

Mr. CAZARES. Thank you, Mr. Rogers.

STATEMENT OF MARION TRAPMAN

Ms. TRAPMAN. My name is Marion Trapman. I think this was a marvelous hearing, I hope we have a great many more. However, I have a question of Mr. Bilirakis. I would like to know why Mr. Bilirakis did not support aid to Israel when the President did.

Mr. BILIRAKIS. In what way did Mr. Bilirakis not support aid to Israel?

Ms. TRAPMAN. Mr. Bilirakis voted against aid for Israel.

Mr. BILIRAKIS. No, ma'am. Within the 1-minute time, I guess we can cover it. I voted against the Kemp-Long amendment which was foreign aid in general, I have—I am a very strong opponent of general foreign aid unless it is limited to our proven friends and I voted against that particular bill. The amendment which followed that, which was the Wright amendment, included the foreign aid that you are talking about, the specific foreign aid that you are talking about, and it includes some education dollars and that sort of thing; I voted for it. Yes, ma'am, I resent——

Ms. TRAPMAN. Senator Lawton Childs voted for it and Bill McCollom voted for it——

Mr. BILIRAKIS. I voted for the amendment, ma'am, which afforded the increase in foreign aid to Israel, which is the Wright amendment. I did vote for the Wright amendment, yes, ma'am.

STATEMENT OF BARBARA STEWART

Ms. STEWART. My name is Barbara Stewart and I would like to know if there is any way you can put a stop to some of the alcohol advertisement on television. That is like creating alcoholics. We put a stop to some of it for cigarette smoking, I do not see why the same thing cannot be done for advertisements on television.

Mr. BILIRAKIS. Well the people, ma'am, control and the people should control. This is a republic. If enough of the people want that and let the Congress know that, the same as the 10 percent withholding issue that was repealed because the people clearly wanted it, then it can be done. The people control the Congress. There would be an awful lot of opposition to such a change. However, if this is what the people want, and the demand is great, then I expect that it will be carried forward.

Ms. STEWART. I have one other question. I would like to know is there any way that we can train our local police officers and stuff to be aware of these problems. A lot of times they stop these elderly people and instead of offering to help them, they degrade them a little bit, because they are so young and they do not realize that these people might be on prescription drugs or in fact drinking. Then the people get frightened and scared and they go home and they really do not know what to do. I think these younger police officers need to be trained a little better.

Mr. BILIRAKIS. Thank you.

STATEMENT OF SELMA KOLODZIK

Ms. KOLODZIK. My name is Selma Kolodzik and I would like to know very much about alcoholism referring it as a disease. If an alcoholic is in a car accident, he is fined and taken to jail. Why then is he taken to jail and not to a hospital, if it is a disease?

Also, if a party who has a cardiac condition and may not even have any knowledge of having any cardiac condition and is in an accident, he is taken to the hospital, but not an alcoholic. And I would like to have that——

Mr. BILIRAKIS. Very quickly, I think there is a difference between an alcoholic and someone who is driving under the influence and is a dangerous menace on the highway, not that that person cannot be an alcoholic, but at that particular point he is breaking the law and putting your life and everybody else's life in jeopardy and he should be punished if he is found guilty. An alcoholic obviously is someone who might do things like that but it is a long, lingering, all encompassing 24-hour-a-day type of thing and that person is the one who has the disease and needs the medical care. So I do not think you would say that every person who leaves a bar after drinking too much and becomes a menace on the highway has to be taken to a hospital necessarily and treated as an alcoholic. That person may be an alcoholic and should be treated; then again, the person may not be an alcoholic, and may have just done it on a limited scope.

Ms. KOLODZIK. I do believe in that case it should be clarified at the time.

Mr. CAZARES. Thank you. We will go to the gentleman in the back.

STATEMENT OF MANUEL FELDMAN

Mr. FELDMAN. My name is Manuel Feldman, I am chairman of the Sun Coast Veterans Affiliated Council. I believe that the person that spoke a few minutes ago had no business asking about what the Congressman had voted on various issues. We are here for the purpose of the aid of drug abuse, not on what is going on, whether it be Israel or any other foreign country.

Thank you.

STATEMENT OF IRVING LAUSKY

Mr. LAUSKY. My name is Irving Lausky, I live in Veterans Village and I am also on the board of the Human Development Board.

One problem here we have, like the drug stores, Eckerd and all of them, we have people that get a prescription from a doctor, it could be for 30 or 40 pills, the other doctor will give you the same prescription for 100 pills. The problem is when he goes to his drug store, he will be charged the same thing whether you buy the 30 pills or 100 pills and they tell you that is handling, or whatever it is. They say you can cut your prescription in half, but a doctor will not give you 100 pills a lot of times, he will only give 20 or 30 and say if you want more, you will have to come back again. Can anything be done with the way they charge these prices? There are lots of people who just cannot afford to pay the same price for 20 or 30 pills as they have to pay for 100. What can be done to help them with that problem?

Mr. BILIRAKIS. That is a problem area and of special interest to the Congress, sir, the concern with the increase in the cost of medical care of all sorts, and obviously in this 1-minute timeframe, I am not going to be able to give you a satisfactory answer. There is a concern, believe me. In this committee particularly.

Thank you.

Mr. CAZARES. Thank you.

Yes, ma'am.

STATEMENT OF DOROTHY MYERS

Ms. MYERS. Dorothy Myers. I would like to see a law that would prevent a State from throwing a person who is not an alcoholic, never has been a drug addict either, in the same ward with the alcoholics and drug addicts without a hearing first.

Mr. BILIRAKIS Thank you, Ms. Myers.

Mr. CAZARES. Mr. Congressman, we have no other people here that want to testify. I want to thank all of those who have been here to provide testimony and also to make recommendations to the committee.

I would like to take my 1 minute, Congressman Bilirakis. I want to thank you for asking me to be moderator and at this time I want to assure you that as vice chairman for the Regional Planning Council Area Four Agency, that we will keep in contact with those who have expressed an interest and have asked questions here. We will be interested in receiving your testimony. We want to thank everyone from Pinellas and Pasco County who has come here to participate and to listen and to learn. We think these hearings are very valuable. We want to thank the House Select Committee on Aging for coming here to our Sun coast and we are especially appreciative of your part in bringing the committee here.

Mr. BILIRAKIS. Thank you, Mr. Commissioner.

I might say that this is a very, in a sense, easy district to represent in the fact that they are open, they let us know what their concerns are, they write us letters, they attend hearings such as this one. How better can we impress a congressional committee than to have a good attendance at something like this. We had the veterans' hearing awhile back and we had them standing up against the wall and we had to turn away 3 or 400 people, it was a tremendous attendance and it impressed those people.

So I commend you for caring about your country and of course for caring about yourself and your community.

I guess I have opened up the door for another 1 minute back there. Please go ahead.

VOICE. The Congressman who was sitting in the middle before, I could not read his name.

Mr. BILIRAKIS. Mr. Roybal, Congressman Roybal. He is the chairman of the overall Aging Committee. He really honored us by coming here for this hearing.

Mr. CAZARES. I will put in a little plug for him, he comes from my old neighborhood, from east Los Angeles, Calif. I will be able to meet with him later.

Congressman, thank you.

Mr. BILIRAKIS. Thank you very much for your attendance.

The hearing is adjourned.

[Whereupon, at 11:55 a.m., the hearing was adjourned.]